89 24642

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George W. Payne			2. DATE OF DEATH (Month / Day / Year): 9 / 6 / 89	3. TIME OF DEATH: 10 15 AM
4. SOCIAL SECURITY NUMBER: 220-20-8172	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 61 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 3/18/1928	8. BIRTHPLACE (State or Foreign Country): Baltimore MD
9a. FACILITY NAME (If not institution, give street and number): 1024 N Luzerne Ave		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Maryland
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: U.S.A.	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1024 N Luzerne Ave		10f. ZIP CODE: 21205		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tow Truck Drive	16b. KIND OF BUSINESS/INDUSTRY: Towing Co.		
17. FATHER'S NAME (First, Middle, Last): Samuel Payne		18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Scott		
19a. INFORMANT'S NAME (Type/Print): Beatrice Payne	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1024 N Luzerne Ave Balto Md. 21205			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park	20c. LOCATION — City or Town, State: Arbutus, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randolph J. Collick	22. NAME AND ADDRESS OF FACILITY: 2431 E. Oliver St. Collick F.H. Baltimore, Md 21213			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. hyperammonemic coma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. profound hypercatabolism	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Liver failure	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Systemic Lupus erythematosis

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Salim Dabagh, MD / Howard Stein	D38405	▶ Sept 6, 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): The Good Samaritan Hospital

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 13 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

10

89 24643

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph F. Pedrazzani / JOSEPH F PEDRAZZANI			2. DATE OF DEATH: MONTH 9 DAY 10 YEAR 89	3. TIME OF DEATH: 4 45 PM
4. SOCIAL SECURITY NUMBER: 716-10-2573	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS, HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4/16/05	8. BIRTHPLACE (State or Foreign Country): Pa.
9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice		9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Balto

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Hunt Valley	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 10725 Lancewood Road		10f. ZIP CODE: 21030	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Welder	16b. KIND OF BUSINESS/INDUSTRY: Pennsylvania Railroad	
17. FATHER'S NAME (First, Middle, Last): Isiaah Pedrazzani		18. MOTHER'S NAME (First, Middle, Maiden Surname): Monica Scaramuzzi	
19a. INFORMANT'S NAME (Type/Print): Beezer Funeral Home		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 719 Spruce Street, Philipsburg, Pennsylvania 16866	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Peter & Paul Cem. 9-12-89	20c. LOCATION — City or Town, State: Philipsburg, Pa.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wallace S. Brooks Jr.		22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ASCVD	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Carla A. Alexander MD	29c. LICENSE NUMBER: D27067	29d. DATE SIGNED (Month, Day, Year) ▶ 9/10/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Carla Alexander MD. Dulaney Valley Rd. Towson, Md

31. DATE FILED (Month, Day, Year): SEP 13 1989	32. REGISTRAR'S SIGNATURE: Esther Davidson Reynolds

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24644

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Augusta C. Preil					2. DATE OF DEATH: MONTH 9 DAY 9 YEAR 89	3. TIME OF DEATH: 18:15 M	
4. SOCIAL SECURITY NUMBER: 213-03-5502	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2-19-1901	8. BIRTHPLACE (State or Foreign Country): N.J.	
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH		
RESIDENCE OF DECEDENT							
10a. STATE: Maryland	10b. COUNTY		10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO		
10e. STREET AND NUMBER: 3206 Batavia Ave.			10f. ZIP CODE: 21214		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Yrs. / College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bookkeeper		16b. KIND OF BUSINESS/INDUSTRY: Furniture Co.		
17. FATHER'S NAME (First, Middle, Last): Frank Schleisner			18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Bliederhuser				
19a. INFORMANT'S NAME (Type/Print): Dale E. Lloyd			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 805 Litchfield Rd., Balto., Md. 21239				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery 9/13/89		20c. LOCATION — City or Town, State: Baltimore, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Roy H. Cather Roy H. Cather			22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. pneumonia	10 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

malnutrition
Cerebrovascular disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Stephanie B. Strauss, MD		▶ 9/9/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S. Strauss Union Memorial Hospital

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 13 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3-should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 24645

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lamont Rivers			2. DATE OF DEATH (Month, Day, Year): 9-11-89	3. TIME OF DEATH: 9:56PM M
4. SOCIAL SECURITY NUMBER: 212-86-5829	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 18 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12/28/70	8. BIRTHPLACE (State or Foreign Country): BALTO., MD
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5647 GOVANE AVENUE		10f. ZIP CODE: 21212		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED		16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): GLEN KENNETH RIVERS, JR.			18. MOTHER'S NAME (First, Middle, Maiden Surname): LOUISE FRANKLIN	
19a. INFORMANT'S NAME (Type/Print): LOUISE RIVERS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5647 GOVANE AVENUE/BALTIMORE, MD 21212		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET CEM		20c. LOCATION — City or Town, State: OWINGS MILLS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Anthony E. Ward Jr.		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gunshot wound of chest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	[X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
[X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide [X] 4 Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	9-11-89	9:15PM	1 [ ] YES [X] NO	Subject shot
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Street			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Bennighans & Clear Spring Baltimore City, Maryland

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Julia C. Goodin, M.D.	OCME	▶ 9-12-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 13 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

89 24646

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Frank Roh Jr.			2. DATE OF DEATH (Month, Day, Year): 9-6-89	3. TIME OF DEATH: 10:14AM M
4. SOCIAL SECURITY NUMBER: 216-32-8316	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 6 1912	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): 2403 Chesterfield Avenue		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: -----
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: -----	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2403 Chesterfield Ave.		10f. ZIP CODE: 21213		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Grocer		16b. KIND OF BUSINESS/INDUSTRY: Grocery Store
17. FATHER'S NAME (First, Middle, Last): John F. Roh, Sr.			18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Cada	
19a. INFORMANT'S NAME (Type/Print): Mildred J. Roh (wife)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2403 Chesterfield Ave. Balto. Md. 21213		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Most Holy Redeemer Cemetery		20c. LOCATION — City or Town, State: Balto. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral HOme Inc. 3331 Brehms Lane, Balto. Md. 21213		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory srrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dilated cardiomyopathy, Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES [X] NO — INSPECTION

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number; City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.E. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 9-7-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. KOkes, M.D. 111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year): SEP 13 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24647

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Nancy Robert		2. DATE OF DEATH (Month, Day, Year): September 10, 1989	3. TIME OF DEATH: 1:12 P M
4. SOCIAL SECURITY NUMBER: 254-22-1018A	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 31, 1900
8. BIRTHPLACE (State or Foreign Country): Georgia			
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City	9c. COUNTY OF DEATH	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 921 Kevin Road	10f. ZIP CODE: 21229	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cook	16b. KIND OF BUSINESS/INDUSTRY: Private Family
17. FATHER'S NAME (First, Middle, Last): Allen Scott		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Jane Gibson	
19a. INFORMANT'S NAME (Type/Print): Ernest White		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1822 Hanson Road Edgewood, Maryland 21040	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland National Memorial Park	20c. LOCATION — City or Town, State: Prince Georges Co., MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Nutter		22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetions that caused the death. Do not enter the moda of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximete Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia Right Lung	12 Hours
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. New Cerebrovascular Accident Left	12 Hours
DUE TO (OR AS A CONSEQUENCE OF):		
	c. Left Lower Lobe Pneumonia	3 Days
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.: Syndrome of Inappropriate Antidiuretic Hormone

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCUREO		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.	29c. LICENSE NUMBER: n/a	29d. DATE SIGNED (Month, Day, Year): 9/11/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ernest Uzicanin, M.D. c/o Maryland General Hospital

31. DATE FILED (Month, Day, Year): SEP 13 1989	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

Items:23 thru 28f per ME G-657
11-6-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO. 89 24648

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rachel RENE Rodman						2. DATE OF DEATH: MONTH 9 DAY 7 YEAR 89	3. TIME OF DEATH: 9:30AM M
4. SOCIAL SECURITY NUMBER: 213-25-1467	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 0 YRS.	IF UNDER 1 YEAR: MONTHS 1 DAYS 26	IF UNDER 24 HRS.: HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year): 7-10-1989	8. BIRTHPLACE (State or Foreign Country): Wicomico Co.
9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City			9c. COUNTY OF DEATH:	
RESIDENCE OF DECEDENT							
10a. STATE: Md.	10b. COUNTY: Wicomico		10c. CITY, TOWN OR LOCATION: Hebron			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 106 West Church St.			10f. ZIP CODE: 21830			10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0	College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Never Worked			16b. KIND OF BUSINESS/INDUSTRY: ----	
17. FATHER'S NAME (First, Middle, Last): Robert R. Rodman, Jr.						18. MOTHER'S NAME (First, Middle, Maiden Surname): Donna Carol Weiss	
19a. INFORMANT'S NAME (Type/Print): Donna Weiss			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 106 West Church St. Hebron, Md. 21830				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Springhill Mem. Gardens			20c. LOCATION — City or Town, State: Hebron, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gerald C Bounds			22. NAME AND ADDRESS OF FACILITY: Bounds Funeral Home 705 East Main St. Salisbury, Md.				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. NO ANATOMIC CAUSE OF DEATH	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 9-3-89	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: UNDETERMINED UNKNOWN
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 106 W Church Street Hebron, Wicomico Co., Md.

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell, M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 9-8-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201 VC		
31. DATE FILED (Month, Day, Year): SEP 13 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Reddick	

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

20

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24649

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FREIDA WOLK ROSENSTOCK ~~ROSENSTOCK FRIEDA~~
2. DATE OF DEATH: MONTH 9 DAY 7 YEAR 89
3. TIME OF DEATH: 12~~43~~ pm M
4. SOCIAL SECURITY NUMBER: 219-30-5630
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): AUG. 4, 1910
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3000 FALLSTAFF MANOR CT., APT. E
10f. ZIP CODE: 21209
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY: AT HOME
17. FATHER'S NAME (First, Middle, Last): MORRIS WOLK
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY BRISKMAN
19a. INFORMANT'S NAME (Type/Print): GEORGE H. ROSENSTOCK
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4703 DUNCANNON RD. BALTO., MD 21208
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE HEBREW CEMETERY
20c. LOCATION — City or Town, State: REISTERSTOWN, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joel D Levine
22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel diseese or condition resulting in death) →	a. Metastases to Brain	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	b. Small cell carcinoma of Lung	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: M.B., B.S.
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 9/7/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SINAI HOSPITAL OF BALTIMORE — VINCENT KWOK KWEN TAM
31. DATE FILED (Month, Day, Year): SEP 7 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

20

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24650 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Leo Joseph Rosendale			2. DATE OF DEATH (Month, Day, Year): 9 11 89	3. TIME OF DEATH: 7:40P M
4. SOCIAL SECURITY NUMBER: 216-01-9368	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 H.S.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3/12/12	8. PLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION:		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 6315 Mt. Ridge Road		10f. ZIP CODE: 21228		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [XX] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CPA		16b. KIND OF BUSINESS/INDUSTRY: Burns & Russell Co	
17. FATHER'S NAME (First, Middle, Last): Aloysius H. Rosendale		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Downey		
19a. INFORMANT'S NAME (Type/Print): Loretta Rosendale		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6315 Mt. Ridge Road Balto. MD 21228		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery	20c. LOCATION — City or Town, State: Baltimore, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Roland P. Stark Jr.		22. NAME AND ADDRESS OF FACILITY: Sterling Ashton Funeral Home P.A. 736 Edmondson Ave. Balto. MD 21228		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIOMYOPATHY DUE ISCHEMIC HEART DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. SEPTIC SHOCK 2° TO PSEUDOMONAS SEPSIS.	22 DAYS.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	28. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Roger Chimerty MD (RESIDENT)	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 9-11-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROGER CHIMERTY ST AGNES HOSPITAL 900 CATON AVE BALTIMORE ~~227~~ 21229		
31. DATE FILED (Month, Day, Year): SEP 13 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

5

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24651 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marcella Rotundo
2. DATE OF DEATH (Month, Day, Year): 5-11-89
3. TIME OF DEATH: 3:40 P M
4. SOCIAL SECURITY NUMBER: 219-16-3972
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7. DATE OF BIRTH (Month, Day, Year): 2-15-25
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): MFL/PSK Eastern Ave
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Balt

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 4110 Ardley Ave
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Wht.
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th. College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: home
17. FATHER'S NAME (First, Middle, Last): Frederick Friedel
18. MOTHER'S NAME (First, Middle, Maiden Surname): Isabelle Ketchum
19a. INFORMANT'S NAME (Type/Print): Carmin Rotundo
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4110 Ardley Avenue, Baltimore, Md. 21213
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oaklawn cemetery
20c. LOCATION — City or Town, State: Balto.,Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph N. Zannino, Jr.
22. NAME AND ADDRESS OF FACILITY: Joseph N. Zannino, Jr. Funeral Home 263 S. Conkling Street, 21224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary Edema
DUE TO (OR AS A CONSEQUENCE OF): b. Renal Failure
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF): c. Sepsis.
DUE TO (OR AS A CONSEQUENCE OF): d. Multi infarct Dementia.

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HTN - Recurrent UTI
Pneumonia - Pressure Sores -
DJD - FOOM - 1

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: W.G.S. MD
29c. LICENSE NUMBER: D04383
29d. DATE SIGNED (Month, Day, Year): 9/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Linda AC/Greenough MD MFL Eastern Ave Balt. Md
31. DATE FILED (Month, Day, Year): SEP 1989
32. REGISTRAR'S SIGNATURE:

DHMH-16 Rev 1/89

89 24652

4

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Isidoros	G.	Roros	9 - 10 - 89	9:45 AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
218-64-3958	1 [X] M 2 [ ] F	79 YRS.			7-24-1910	Greece

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
731 Umbra Street	Baltimore	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland		Baltimore	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
731 Umbra Street	21224	Greece

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
6th	-----	Sailor & Baker	H&S Bakery

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
George Roros	Kiriaki Klosterides

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Irini Roros	731 Umbra Street Baltimore, Maryland 21224

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Oaklawn Cemetery	Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Joseph N. Zannino Jr.	Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street Balto. Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D 37811	9/11/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John Crosthan, MD Bracken Center 5200 Eastern Ave Baltimore MD 21224

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 13 1989	Julie Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24653
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RMOUTIL ROSE RMOUTIL, ROSE A		2. DATE OF DEATH: MONTH 09 DAY 10 YEAR 89	3. TIME OF DEATH: 6:00 A.M. 6 A M
4. SOCIAL SECURITY NUMBER: 213 80 3142	5. SEX: 1 ☐ M 2 ☒ F X	6. AGE (In yrs. last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1/2/13	8. BIRTHPLACE (State or Foreign Country): Maryland		
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH:	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Essex	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1000FRANKLIN AVE APT. 708	10f. ZIP CODE: 21221	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married XXX 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Homemaking	
17. FATHER'S NAME (First, Middle, Last): Salvadore Taormina	18. MOTHER'S NAME (First, Middle, Maiden Surname): Theresa Scurto		
19a. INFORMANT'S NAME (Type/Print): Theresa M. Steele	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Bridgeview Ct. Baltimore, Maryland 21236		
20a. METHOD OF DISPOSITION: XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery	20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lasuka Funeral Home	22. NAME AND ADDRESS OF FACILITY: 7401 Belair Rd. Baltimore, Maryland		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. BACTEREMIA SEPSIS
BACTEREMIA - SEPSIS -
DUE TO (OR AS A CONSEQUENCE OF):
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
CONGESTIVE HEART FAILURE.
c. CONGESTIVE HEART FAILURE.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS - DIABETES MELLITUS.
RHEUMATOID ARTHRITIS RHEUMATOID ARTHRITIS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO X	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural X 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: JOSEPH HUBAYKAN, M.D. MD	29c. LICENSE NUMBER: D37233 D37233	29d. DATE SIGNED (Month, Day, Year): 09/10/89 ▶ 09/10/89	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH HUBAYKAN JOSEPH HUBAYKAH	CHURCH HOSPITAL CHURCH HOSPITAL		
31. DATE FILED (Month, Day, Year): SEP 13 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24654 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LYNDOLL VIRGINIA ROSK			2. DATE OF DEATH (Month / Day / Year): 9 / 8 / 89	3. TIME OF DEATH: 5:27 AM
4. SOCIAL SECURITY NUMBER: 215-12-3840	6. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-10-1910	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: DUNDALK		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1924 DENBURY DRIVE		10f. ZIP CODE: 21222		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NOT KNOWN; College (1-4 or 5+): NOT KNOWN	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOME MAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME		
17. FATHER'S NAME (First, Middle, Last): GEORGE HARTMAN		18. MOTHER'S NAME (First, Middle, Maiden Surname): FLORENCE BECKS		
19a. INFORMANT'S NAME (Type/Print): DONNA RHONE	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 802 S. LINWOOD AVENUE BALTIMORE, MARYLAND 21224			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WOODLAWN CEMETERY 9-11-1989	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the desth. Do not enter the mode of dying, such ss cardiac or respiratory srrest, shock, or heart failure. List only ona ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Failure — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. COPD — DUE TO (OR AS A CONSEQUENCE OF):	
	c. Cigarette Smoking — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
BRIAN LEWIS, RESIDENT M.D.	D3P091	9/8/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BRIAN LEWIS

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 13 1989	Julia Davidson

DHMH-16 Rev 1/89

- 1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24655

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDGAR SMALL

2. DATE OF DEATH Month: 9 Day: 9 Year: 89

3. TIME OF DEATH: 3 55 PM

4. SOCIAL SECURITY NUMBER: 264-12-4171

5. SEX: 1 ☒ M 2 ☐ F

6. AGE (In yrs. last birthday): 66 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 4/14/23

8. BIRTHPLACE (State or Foreign Country): MD

9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL Belvedere & Greenspring

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Balto Md.

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 2609 WOODLAND AVE.

10f. ZIP CODE: 21215

10g. CITIZEN OF WHAT COUNTRY?: U.S.A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES ( )

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4 or 5+): N/A.

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic

16b. KIND OF BUSINESS/INDUSTRY: Private Work

17. FATHER'S NAME (First, Middle, Last): UNKNOWN

18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN

19a. INFORMANT'S NAME (Type/Print): Mollie Everett

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2609 Woodland Ave. 21215

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery 9/14/89.

20c. LOCATION — City or Town, State: Balto Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Rodney S. Sykes

22. NAME AND ADDRESS OF FACILITY: Rodney T. Sykes 4624 Rim Rock Rd.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Upper and Lower Motor Neuron Disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Cardiac / Respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. Dabbah MD

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): 9/9/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. DABBAH MD

31. DATE FILED (Month, Day, Year): SEP 13 1989

32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24656
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THERSIA K. SMITH
2. DATE OF DEATH: MONTH 9 DAY 11 YEAR 89
3. TIME OF DEATH: 10 15 PM
4. SOCIAL SECURITY NUMBER: 213-01-1493
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3/16/16
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY MED CEN.
9b. CITY, TOWN OR LOCATION OF DEATH: Balto
9c. COUNTY OF DEATH: -----

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: ------
10c. CITY, TOWN OR LOCATION: Balto
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4436 CLAREWAY
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a — College (1-4 or 5+): n/a
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISABILITY
16b. KIND OF BUSINESS/INDUSTRY: ------
17. FATHER'S NAME (First, Middle, Last): GEORGE BROOKS
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET CONSTANCE
19a. INFORMANT'S NAME (Type/Print): GRACE MARY WOLF (SISTER)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4436 CLAREWAY BALTIMORE, MD. 21213
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METRO CREMATORY INC.
20c. LOCATION — City or Town, State: BALTIMORE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Brian D. Francis
22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Balto. Md. 21213

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Resp. Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Metastatic Lung CA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D37030
29d. DATE SIGNED (Month, Day, Year): 9/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Francis Scott Key Medical Center Balt. Md. 21224
31. DATE FILED (Month, Day, Year): SEP 13 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24657

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Willie Sams			2. DATE OF DEATH (Month, Day, Year): September 12, 1989	3. TIME OF DEATH: 1:45A M
4. SOCIAL SECURITY NUMBER: 246-18-9575	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 3/22/15	8. BIRTHPLACE (State or Foreign Country): N. CAROLINA
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2212 PENNSYLVANIA AVENUE		10f. ZIP CODE: 21217	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY: Allegany Utility Corp.
17. FATHER'S NAME (First, Middle, Last): WILLIE SAMS, SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): DANA SAMS	
19a. INFORMANT'S NAME (Type/Print): NAOMI SAMS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2212 PENNSYLVANIA AVE: BALTO, MD 21217	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR CEMETERY	20c. LOCATION — City or Town, State: CATONSVILLE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leroy O. Dyett		22. NAME AND ADDRESS OF FACILITY: LEROY O. DYETT & SON F.H., INC. 4600 LIBERTY HEIGHTS AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Pancreatic Carcinoma with decreased immunity, Metastasis.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypovolume secondary to common bile duct drainage

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Bhajanial S. Dara.	29c. LICENSE NUMBER: n/a	29d. DATE SIGNED (Month, Day, Year) ▶ 9/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bhajanial Dara, M.D. c/o Maryland General Hospital		
31. DATE FILED (Month, Day, Year): SEP 13 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24658

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be detached by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT G. SMITH			2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 10, 1989	3. TIME OF DEATH: 5:56 P M
4. SOCIAL SECURITY NUMBER: 218-36-3114	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 48 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-15-1940	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION:	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO XX
10e. STREET AND NUMBER: 10624 Davis Ave.		10f. ZIP CODE: 21163	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Auto Body Technician	16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Frank A. Smith		18. MOTHER'S NAME (First, Middle, Maiden Surname): Doris H. Clark	
19a. INFORMANT'S NAME (Type/Print): Sandra K. Smith		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10624 Davis Ave. Woodstock, Md. 21163	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory	20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Wm C Brown		22. NAME AND ADDRESS OF FACILITY: Wm.C.Brown Comm.F.H. 1206 W. North Ave.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	refractory Ventricular Tachycardia	30 min
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	S/P Orthotic liver Transplant	3 days
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Adult Respiratory distress syndrome	1½ days
DUE TO (OR AS A CONSEQUENCE OF):		
d.	Tension Pneumothorax	1 hour

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Timothy G. Howell MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): 9/10/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Timothy Howell, MD Johns Hopkins Hospital, Block 14 Baltimore, Md. 21205

31. DATE FILED (Month, Day, Year): SEP 13 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24659

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PEARL STALLINGS					2. DATE OF DEATH MONTH: 09 DAY: 11 YEAR: 89		3. TIME OF DEATH: 10 A M
4. SOCIAL SECURITY NUMBER: 217264950	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 93 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 09-11-16		8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore			9c. COUNTY OF DEATH:	
RESIDENCE OF DECEDENT							
10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO		
10e. STREET AND NUMBER: 2845 Edgecombe Circle North		10f. ZIP CODE: 21215			10g. CITIZEN OF WHAT COUNTRY?: U. S. A.		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic	16b. KIND OF BUSINESS/INDUSTRY: Homemaker					
17. FATHER'S NAME (First, Middle, Last): Jack Saunders		18. MOTHER'S NAME (First, Middle, Maiden Surname): Laura Williams					
19a. INFORMANT'S NAME (Type/Print): Jerry Stallings		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2845 Edgecombe Circle North Baltimore, MD 21215					
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star Cemetery			20c. LOCATION — City or Town, State: Baltimore County, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ACUTE MYOCARDIAL INFARCTION.	2 HRS.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. SEVERE 3 VESSELS TRIP CORONARY ARTERY DISEASE. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CONGESTIVE HEART FAILURE.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
PShah INTERN.	—	▶ 09-11-89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PRADIP SHAH, MD. Good Samaritan Hosp., Baltimore, MD. 21239.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 13 1989	Jackie Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24660

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elmer V. Staubitz		2. DATE OF DEATH: MONTH 9 DAY 9 YEAR 89	3. TIME OF DEATH: 8:10 P. M
4. SOCIAL SECURITY NUMBER: 217-07-2950	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12-15-11
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): 661 Red Cedar Road	9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis	9c. COUNTY OF DEATH: Anne Arundel	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Annapolis	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 661 Red Cedar Road	10f. ZIP CODE: 21401	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Printer	16b. KIND OF BUSINESS/INDUSTRY: Printing Company	
17. FATHER'S NAME (First, Middle, Last): Elmer Staubitz	18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Vaeth		
19a. INFORMANT'S NAME (Type/Print): Robert J. Brown	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5403 Dolores Avenue Baltimore, MD 21227		
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery	20c. LOCATION — City or Town, State: Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie N. Shannon	22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Carcinoma of Rectum with liver	6 mos.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. and abdominal metastases	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 5 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
David Matteson M.D.	BM 0986844	▶ 9-11-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David Matteson 107 Ridgley Ave, Annapolis, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 13 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24661
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BERTHA (BERTHA) SCHULMAN (SCHULMAN)			2. DATE OF DEATH (Month, Day, Year): 9 8 89	3. TIME OF DEATH: 0715 M
4. SOCIAL SECURITY NUMBER: 218-22-2197	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 94 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): SEPT. 25, 1894	8. BIRTHPLACE (State or Foreign Country): GERMANY
9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GEN. HOSP.			9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN	9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 7011 FIELDCREST RD.		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES XX NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: AT HOME	
17. FATHER'S NAME (First, Middle, Last): SAMUEL WOLFE BRAFMAN		18. MOTHER'S NAME (First, Middle, Maiden Surname): FRIEDA UNKNOWN	
19a. INFORMANT'S NAME (Type/Print): BRUNO SCHULMAN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7001 FIELDCREST RD. BALTO.,MD 21208	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHEVRA AHAVAS CHESED	20c. LOCATION — City or Town, State: RANDALLSTOWN,MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sydney L. Stullman		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS.,INC. 6010 REISTERSTOWN RD. BALTO.,MD 21215	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ASPIRATION PNEUMONIA	0' MIN
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

FECAL ~~OBSTRUCTION~~ IMPACTION, ABDOMINAL DISTENTION; CHF, A-FIB; GOUT, COPD

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: C. Ravi MD	29c. LICENSE NUMBER: D37333	29d. DATE SIGNED (Month, Day, Year) ▶ 9.8.89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. RAVI MD, BCAH, RANDALLSTOWN, MD. 21133.

31. DATE FILED (Month, Day, Year): SEP 13 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24662

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Goldie I. Shelley			2. DATE OF DEATH (Month, Day, Year): 9 12 89	3. TIME OF DEATH: 4:32 A M
4. SOCIAL SECURITY NUMBER: 220-20-9518	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9-23-09	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): ST JOSEPH HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Rosedale	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1305 Rosewick Avenue		10f. ZIP CODE: 21237	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Homemaker	
17. FATHER'S NAME (First, Middle, Last): Walter Frederick Lease		18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Lease	
19a. INFORMANT'S NAME (Type/Print): Betty L. Johnson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1305 Rosewick Avenue Baltimore, Maryland 21237	
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith	20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Loreneh FH	22. NAME AND ADDRESS OF FACILITY: Loreneh FH	7401 Belair Rd. Baltimore, Md. 21236	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. leukemia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Shortness of breath

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Adams MD	29c. LICENSE NUMBER: D32783	29d. DATE SIGNED (Month, Day, Year): 9/13/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph Adams MD St. Joseph Hospital		
31. DATE FILED (Month, Day, Year): SEP 13 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24663

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12+1

P

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Smith James — James Willman Smith
2. DATE OF DEATH: MONTH 09 DAY 04 YEAR 89
3. TIME OF DEATH: 3:50 P M
4. SOCIAL SECURITY NUMBER: 217-20-5619
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 64 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 12, 1925
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Fallston General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: FALLSTON MD
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Harford
10c. CITY, TOWN OR LOCATION: Pylesville, Md. 21132
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5010 W. Heaps Road,
10f. ZIP CODE: 21132
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Heavy Equipment Operator
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): William Eric Smith
16. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Elizabeth Cooper
19a. INFORMANT'S NAME (Type/Print): Evelyn J. Smith
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5010 W. Heaps Rd, Pylesville, Md. 21132
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Pauls United Methodist
20c. LOCATION — City or Town, State: Pylesville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Frederick G. Konhaus
22. NAME AND ADDRESS OF FACILITY: Hartenstein-Orsburn Funeral HOme 19 S. Main St., Stewartstown, Pa. 17363

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiopulmonary Arrest	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Severe Ischemic heart disease	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	(probable ischemic event)	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D23579
29d. DATE SIGNED (Mo., Day, Yr.) ▶ 9/5/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Robert L Smith MD Fallston General Hospital
31. DATE FILED (Month, Day, Year): 9/5/89 13 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

3

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24664
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sally AKA: (SARAH IDA) Turner			2. DATE OF DEATH (Month, Day, Year): 9-5-89	3. TIME OF DEATH: 5:38PM M
4. SOCIAL SECURITY NUMBER: 213-32-8866	6. SEX: 1 ☐ M 2 X F	6. AGE (In yrs. last birthday): 52 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): OCT 22, 1936	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 316 S. Broadway		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO
10e. STREET AND NUMBER: 316 S. BROADWAY		10f. ZIP CODE: 21231		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12	College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY: AT HOME
17. FATHER'S NAME (First, Middle, Last): LOUIS ALBAUGH			18. MOTHER'S NAME (First, Middle, Maiden Surname): FANNIE TOBESMAN	
19a. INFORMANT'S NAME (Type/Print): MR. EDWARD TURNER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 316 S. BROADWAY BALTO., MD 21231		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SHOMREI ADATH CEMETERY		20c. LOCATION — City or Town, State: ROSEDALE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE:		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease and Morbid Obesity

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic alcoholism

24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO — PARTIAL

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 XX Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 XXX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER:

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): 9-6-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year): SEP 13 1989

32. REGISTRAR'S SIGNATURE: Ruth Davidson-Randall

DHMH-16 Rev 1/89

12

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24665
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES T. SIEGEL, SR.		2. DATE OF DEATH (Month, Day, Year): 09 10 89	3. TIME OF DEATH: 04 20AM M
4. SOCIAL SECURITY NUMBER: 212-24-7577	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 62 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8/27/27
8. BIRTHPLACE (State or Foreign Country): MARYLAND			
9a. FACILITY NAME (If not institution, give street and number): GBMC 6701 N CHARLES ST	9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON	9c. COUNTY OF DEATH: BALTO	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: BALTO	10c. CITY, TOWN OR LOCATION: DUNDALK	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 8037 GRAY HAVEN RD		10f. ZIP CODE: 21222	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11TH GRADE; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ENGINEER	16b. KIND OF BUSINESS/INDUSTRY: PATAPSCO & BACK RIVER R.R.	
17. FATHER'S NAME (First, Middle, Last): WILLIAM JAMES SIEGEL, SR.	18. MOTHER'S NAME (First, Middle, Maiden Surname): FRANCES REBECCA KOHLER		
19a. INFORMANT'S NAME (Type/Print): ADELENA E. SIEGEL	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8037 GRAY HAVEN ROAD BALTIMORE, MARYLAND 21222		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BEL AIR MEMORIAL 9-13-1989	20c. LOCATION — City or Town, State: BEL AIR, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert Hudson	22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CESSATION OF CARDIO-RESPIRATORY FUNCTIONS
DUE TO (OR AS A CONSEQUENCE OF):
b. METASTATIC SQUAMOUS CELL CA OF EPIGLOTIS

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jose O. Delgado MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 9/10/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSE O. DELGADO	GREATER BALTIMORE MEDICAL CENTER	
31. DATE FILED (Month, Day, Year): SEP 13 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 24666

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Baby Boy Watkins				2. DATE OF DEATH (Month, Day, Year): 5 6 89	3. TIME OF DEATH: 10:15 am M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday) YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. 20	7. DATE OF BIRTH (Month, Day, Year): 5 6 89	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital of Baltimore			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Maryland		9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore City	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 734 Bartlett Ave.		10f. ZIP CODE:	10g. CITIZEN OF WHAT COUNTRY? Baltimore City

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): none; College (1-4 or 5+): none	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): none	16b. KIND OF BUSINESS/INDUSTRY: none	
17. FATHER'S NAME (First, Middle, Last):	18. MOTHER'S NAME (First, Middle, Maiden Surname): Patrice Watkins		
19a. INFORMANT'S NAME (Type/Print): Kathleen Stevens, M.D.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Sinai Hospital, 2401 W. Belvedere Ave., Balto., Md. 21215		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶	22. NAME AND ADDRESS OF FACILITY		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Perinatal Asphyxia
DUE TO (OR AS A CONSEQUENCE OF):
c. Extreme Prematurity
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kathleen Stevens, M.D.	29c. LICENSE NUMBER: D43751	29d. DATE SIGNED (Month, Day, Year) ▶ 9/5/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kathleen Stevens, M.D., Sinai Hospital, 2401 W. Belvedere Ave., Baltimore, Md. 21215

31. DATE FILED (Month, Day, Year): 5-8-89 SEP 12 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24667

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ADDIE WEAVER

2. DATE OF DEATH (Month, Day, Year): 9 / 12 / 89

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 228-52-3259

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 89 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 3/05/1900

8. BIRTHPLACE (State or Foreign Country): EDENTON, NC

9a. FACILITY NAME (If not institution, give street and number): 2522 EAST HOFFMAN STREET

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 2522 E. HOFFMAN STREET

10f. ZIP CODE: 21213

10g. CITIZEN OF WHAT COUNTRY?: USA USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): JOHN BAKER

18. MOTHER'S NAME (First, Middle, Maiden Surname): ELLA

19a. INFORMANT'S NAME (Type/Print): ALPHONSO DILLARD

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2522 E. HOFFMAN STREET/BALTIMORE, MD 21213

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY

20c. LOCATION — City or Town, State: BALTIMORE, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Anthony E. Woolf Jr.

22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F.H. 1101 E. NORTH AVENUE 21202

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mods of dying, such ss cardiec or respiratory srrest, ahock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. MI
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CHF
DUE TO (OR AS A CONSEQUENCE OF):
c. DM
DUE TO (OR AS A CONSEQUENCE OF):
d. HTN

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year):

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED:

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas Kowalski

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): ▶ 9/12/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas Kowalski, Tower 110, JHH, 600 N. Wolfe St. Baltimore, MD

31. DATE FILED (Month, Day, Year): SEP 13 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24668
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANTHONY J. WILINSKI ~~WILINSKI~~ ~~ANTHONY~~
2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 6, 1989 — 9 6 89
3. TIME OF DEATH: 12:45 P M
4. SOCIAL SECURITY NUMBER: 215-10-4134
5. SEX: 1 ☐ M 2 ☐ F — X
6. AGE (In yrs. last birthday): 77 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): JANUARY 7, 1912 — 1-7--12
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2316 COVERED BRIDGE GARTH
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY?: US
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): TWELVE YEARS — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ELECTRICIAN
16b. KIND OF BUSINESS/INDUSTRY: WESTERN ELECTRIC
17. FATHER'S NAME (First, Middle, Last): THOMAS WILINSKI
18. MOTHER'S NAME (First, Middle, Maiden Surname): KATHERINE ZAWALICK
19a. INFORMANT'S NAME (Type/Print): BARBARA M. WILINSKI (DAUGHTER)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2316 COVERED BRIDGE GARTH, BALTIMORE, MARYLAND 21234
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ENTOMBMENT
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DULANEY VALLEY MAUSOLEUM
20c. LOCATION — City or Town, State: TIMONIUM, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dennis A. Schimunek
22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD, BALTIMORE, MARYLAND 21236

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive heart Failure.
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. MYOCARDIAL Infarction.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: EMPHYSEMA.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: A.H. Ghiladi M.D.
29c. LICENSE NUMBER: D12849
29d. DATE SIGNED (Month, Day, Year): ▶ 9-6-89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A.H. GHILADI, M.D. 7600 OSLER Dr. Towson Md 21204
31. DATE FILED (Month, Day, Year): SEP 13 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24669

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Esther H. Wallen			2. DATE OF DEATH (Month, Day, Year): 9 / 12 / 89	3. TIME OF DEATH: @ 7 15 A.M
4. SOCIAL SECURITY NUMBER: 214-46-7799	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 94 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6/25/95	8. BIRTHPLACE (State or Foreign Country): South Wales, Eng.
9a. FACILITY NAME (If not institution, give street and number): Meridian Hamilton Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Parkville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3608 Hallmark Ct.		10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY? UKXXXA. Great Britain

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home

17. FATHER'S NAME (First, Middle, Last): Morgan Phillips	18. MOTHER'S NAME (First, Middle, Maiden Surname): Hanna Jane Thomas
19a. INFORMANT'S NAME (Type/Print): Anna V. Wallen	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3608 Hallmark Ct., Baltimore, MD 21234

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Crematory	20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balitmore, MD 21214	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute M.I.	1 hr
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. ASCVD with cardiomegaly	
	DUE TO (OR AS A CONSEQUENCE OF): c. and cardiac arrhythmia	
	DUE TO (OR AS A CONSEQUENCE OF): d. hiatal hernia	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	26e. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.	29c. LICENSE NUMBER: DO 2180	29d. DATE SIGNED (Month, Day, Year) ▶ 9/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 8014 Old Harford Rd, Baltimore, Md, 21234		
31. DATE FILED (Month, Day, Year): SEP 13 1989	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24670
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Amber Marie Wallace

2. DATE OF DEATH (Month, Day, Year): Sept. 8, 1989

3. TIME OF DEATH: 14:50 PM

4. SOCIAL SECURITY NUMBER: None

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS 11 / MIN. 50

7. DATE OF BIRTH (Month, Day, Year): Sept. 8 89

8. BIRTHPLACE (State or Foreign Country): Baltimore

9a. FACILITY NAME (If not institution, give street and number): University Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore

9c. COUNTY OF DEATH: None

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Anne Arundel

10c. CITY, TOWN OR LOCATION: Glen Burnie

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 15 Marley Neck Road

10f. ZIP CODE: 21061

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): None
College (1-4 or 5+): None

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None

16b. KIND OF BUSINESS/INDUSTRY: N/A

17. FATHER'S NAME (First, Middle, Last): Stephen H. Wallace

18. MOTHER'S NAME (First, Middle, Maiden Surname): Theresa L. Wilson

19a. INFORMANT'S NAME (Type/Print): Stephen H. Wallace

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10 A

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery

20c. LOCATION — City or Town, State: Brooklyn, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶

22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W.
Singleton Funeral Home, Glen Burnie, Md. 21061

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Immature Lungs
DUE TO (OR AS A CONSEQUENCE OF):
c. Extreme prematurity
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY — M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED: —

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): —

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): —

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Constantine Sorkin MD

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year) ▶ 9/8/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Constantine Sorkin MD, Univ Med Hospital

31. DATE FILED (Month, Day, Year): 9/SEP/12 1989

32. REGISTRAR'S SIGNATURE

DNMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24671

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ZELDA C. WAGENHEIM			2. DATE OF DEATH (Month, Day, Year): SEPT. 8, 1989	3. TIME OF DEATH: 1:10 PM M
4. SOCIAL SECURITY NUMBER: 217-05-3336	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): SEPT. 15, 1909	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GEN. HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN		9c. COUNTY OF DEATH: BALTIMORE
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 7219 PARK HEIGHTS AVE, APT. T-6		10f. ZIP CODE: 21208		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY: AT HOME
17. FATHER'S NAME (First, Middle, Last): AARON COHEN			18. MOTHER'S NAME (First, Middle, Maiden Surname): SARAH GERBER	
19a. INFORMANT'S NAME (Type/Print): SAMUEL WAGENHEIM		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7219 PARK HEIGHTS AVE., APT. T-6 BALTO.,MD 21208		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON (CHIZUK AMUNO)		20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sydney H. Stillman		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO.,MD 21215		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aortic Stenosis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Severe CHD

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Stephen H. Pollock

29c. LICENSE NUMBER: D19236

29d. DATE SIGNED (Month, Day, Year): 9/9/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 2724 N. Charles St. 21218 Stephen H. Pollock

31. DATE FILED (Month, Day, Year): SEP 13 1989

32. REGISTRAR'S SIGNATURE: Esther Davidson-Randall

DHMH-16 Rev 1/89

15

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24672
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BENJAMIN WOHLGEMUTH				2. DATE OF DEATH (Month, Day, Year): 9-6-89	3. TIME OF DEATH: 8:30 PM
4. SOCIAL SECURITY NUMBER: 050-03-2797	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 6-23-05	8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: FL.	10b. COUNTY: PALM BEACH	10c. CITY, TOWN OR LOCATION: PALM BEACH	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 325 VIA LINDA		10f. ZIP CODE: 33480	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 8+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OWNER	16b. KIND OF BUSINESS/INDUSTRY: MONUMENTS
17. FATHER'S NAME (First, Middle, Last): UNKNOWN WOHLGEMUTH		18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN	
19a. INFORMANT'S NAME (Type/Print): MRS. MILDRED WOHLGEMUTH		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 325 VIA LINDA PALM BEACH, FL. 33480	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Cremation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LOUDON PARK	20c. LOCATION — City or Town, State: BALTO., MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jay Levin		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON AND BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD. 21215	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIO PULMONARY ARREST

DUE TO (OR AS A CONSEQUENCE OF):
b. ACUTE MI

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. CORONARY INSUFFICIENCY

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: P. Snello M.D.	29c. LICENSE NUMBER: D22647	29d. DATE SIGNED (Month, Day, Year): 9-6-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): PATRICIA SNELLO, M.D. SINAI HOSPITAL

31. DATE FILED (Month, Day, Year): SEP 13 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

4

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24673

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ISABEL A WARD				2. DATE OF DEATH: MONTH 9 DAY 7 YEAR 89	3. TIME OF DEATH: 3:45P M
4. SOCIAL SECURITY NUMBER: 216-24-9375	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 09/02/13	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: Baltimore	10c. CITY TOWN OR LOCATION:	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 718 MIDDLESEX RD.	10f. ZIP CODE: 21221		10g. CITIZEN OF WHAT COUNTRY? U.S.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine Operator	16b. KIND OF BUSINESS/INDUSTRY: Maryland Cup Corp.	
17. FATHER'S NAME (First, Middle, Last): Unk Freize	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ginny Heddings		
19a. INFORMANT'S NAME (Type/Print): Kenneth E. Hile	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 718 Middlesex Rd.Baltimore, Md. 21221		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Cemetery	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: John A. Moran Funeral Home, Inc. 3200 E. Baltimore St.Balto.Md.21224		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CANCER OF LUNG	MONTHS
	DUE TO (OR AS A CONSEQUENCE OF): CANCER OF LUNG	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. R. Nazemi M.D.	29c. LICENSE NUMBER: CHURCH H.	29d. DATE SIGNED (Month, Day, Year): ▶ 9/7/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. ATAOLLAH F. NAZEMI CHURCH HOSPITAL BALTIMORE, MD. ~~21231~~ 21231		
31. DATE FILED (Month, Day, Year): SEP 13 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

9

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24674 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Myomer Watts			2. DATE OF DEATH (Month, Day, Year): September 7, 1989	3. TIME OF DEATH: 6:00A M
4. SOCIAL SECURITY NUMBER: 212-30-6723	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6/25/04	8. BIRTHPLACE (State or Foreign Country): S.C.
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1102 Druid Hill Ave. Apt. 1215		10f. ZIP CODE: 21217		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): W. Bogen Sumter		18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Sumter		
19a. INFORMANT'S NAME (Type/Print): Annie Butler		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9711 Ames Ct. Randallstown, Md. 21133		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Auburn Cemetery		20c. LOCATION — City or Town, State: Westport, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Cecil A Estep		22. NAME AND ADDRESS OF FACILITY: Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21217		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Septic Shock	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): Rule Out b. Pacemaker Failure	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of the Esophagus
Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Hadi MD	n/a	▶ 9/7/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Hussein Abdulhadi, M.D. c/o Maryland General Hospital

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 13 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

20

B

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24675

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
TOWJA	ZABLUDOWSKI	SEPTEMBER 8, 1989	9:45 A.M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
218-06-9556	1 [X] M 2 [ ] F	87 YRS.			FEB. 24, 1902	POLAND

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
MILFORD MANOR NURSING HOME	PIKESVILLE	BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND		BALTIMORE	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4004 FORDS LANE	21215	u.s.a.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	1 [ ] YES 2 [X] NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		TECHNICIAN	TELEPHONE

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
BENJAMIN ZABLUDOWSKI	DEVORA CHOSE

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BENJAMIN ZABLUDOWSKI	2415 TANEY RD. BALTIMORE, MD. (21209)

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	CHEVRA AHAVAS CHESED CEM	RANDALLSTOWN, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Sydney L. Stellman	SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215)

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	hrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. decubutis ulcers	Months
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Multiple CVA's	Yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Louis W. Miller MD	D0742 1	▶ 9/8/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
Louis W. Miller MD	4000 Old Ct Rd 21208

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 13 1989	Julie Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24676
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mittie Plummer BOWLING
2. DATE OF DEATH (Month, Day, Year): September 11, 1989
3. TIME OF DEATH: 2:50P M
4. SOCIAL SECURITY NUMBER: 219-34-7721
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Feb. 14, 1903
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Doctor's Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Lanham
9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: Bowie
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 15910 Pinecroft Lane
10f. ZIP CODE: 20716
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): (12) — College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Deputy Register of Wills
16b. KIND OF BUSINESS/INDUSTRY: Prince Geo's County, Md.
17. FATHER'S NAME (First, Middle, Last): John Dominic Bowling
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mildred Wallace Nalle
19a. INFORMANT'S NAME (Type/Print): Richard B. Edelen
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15910 Pinecroft Lane, Bowie, Md. 20716
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory
20c. LOCATION — City or Town, State: Alexandria, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard A. Coleman
22. NAME AND ADDRESS OF FACILITY: Richard A. Coleman Funeral Home, Upper Marlboro, Maryland 20772

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Myocardial infarct.	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Cardio-respiratory arrest.	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Anemia.	
DUE TO (OR AS A CONSEQUENCE OF):		
d.	decubitus ulcers, infected.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D14156
29d. DATE SIGNED (Month, Day, Year): ▶ 9.12.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ciro Montanez, M.D. 5308 Dodge Park Rd Landover MD 20785
31. DATE FILED (Month, Day, Year): SEP 16 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24677
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert S. Byrd			2. DATE OF DEATH: MONTH 9 DAY 12 YEAR 89	3. TIME OF DEATH: 12:00 pM
4. SOCIAL SECURITY NUMBER: 214-30-5117	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 57 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2-27-1932	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 1701 Appleton Street		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1701 Appleton Street		10f. ZIP CODE: 21217		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): William Byrd		18. MOTHER'S NAME (First, Middle, Maiden Surname): Estelle Clee		
19a. INFORMANT'S NAME (Type/Print): Mrs. Bernadette Byrd		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1701 Appleton Street, Balto., MD 21217		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest V.A. Cem.		20c. LOCATION — City or Town, State: Balto. Co., MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph L. Russ		22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home, 2222-26 West North Avenue, Balto., MD 21216		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Inamation with respiratory arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Squamous Cell Carcinoma of Head and Neck 4 mo	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Marcia L Weil MD Clinical Associate MC		09/14/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 14 1989	Gina Davidson-Randall

DHMH-16 Rev 1/89

89 24678

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edward J. Betz SR.			2. DATE OF DEATH (Month, Day, Year): September 11, 1989	3. TIME OF DEATH: 11:5 A M
4. SOCIAL SECURITY NUMBER: 218-22-4332	5. SEX: 1 M X 2 F	6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 10, 1899	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): MANOR CARE Towson		9b. CITY, TOWN OR LOCATION OF DEATH: Towson, Maryland		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Essex	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7214 Golden Ring Rd.		10f. ZIP CODE: 21221	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): John Betz		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Berlett	
19a. INFORMANT'S NAME (Type/Print): Edward J. Betz, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6227 Hutschenreuter Rd. Glen Arm, Md. 21057	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Zion Church Cemetery	20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lessels Funeral Home		22. NAME AND ADDRESS OF FACILITY: 7401 Belair Rd. Baltimore, Maryland 21236	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute myocardial infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Atherosclerotic Cardiovascular	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. disease.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. Sergio MD	29c. LICENSE NUMBER: D29770	29d. DATE SIGNED (Month, Day, Year): ▶ 9-11-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. Sergio CASSANEGO, MD. 6304 KENWOOD AVE. Balto. 21237		
31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: [illegible] Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24679

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MILDRED BROWN
2. DATE OF DEATH (Month, Day, Year): SEPT. 11 / 89
3. TIME OF DEATH: 7:20 M
4. SOCIAL SECURITY NUMBER: 219-30-9097
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10/13/06
8. BIRTHPLACE (State or Foreign Country): Balto. Md
9a. FACILITY NAME (If not institution, give street and number): Bon Secours Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2801 Riggs Ave.
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY? U.S.A
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Unknown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown
19a. INFORMANT'S NAME (Type/Print): Mrs Mildred Frisby
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2801 Riggs Ave. Balto. Md
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Nat Cem
20c. LOCATION — City or Town, State: Laural P.G. Co. Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ
22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. MASSIVE ACUTE MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c. URINARY TRACT INFECTION
DUE TO (OR AS A CONSEQUENCE OF):
d. STASIS DERMATITIS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Bernardo Gonzales
29c. LICENSE NUMBER: D18711
29d. DATE SIGNED (Month, Day, Year): ▶ Sept. 11/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BERNARDO D. GONZALES M.D. — BON SECOURS HOSPITAL 2000 W. Baltimore, Md. 21223
31. DATE FILED (Month, Day, Year): SEP 14 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24680
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) ANNE REGINA BURNESS		2. DATE OF DEATH (Month, Day, Year) Sept 11, 89	3. TIME OF DEATH 1:00 P.M.
4. SOCIAL SECURITY NUMBER 220-22-8485	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year) Oct. 24 - 07	8. BIRTHPLACE (State or Foreign Country) MARYLAND		

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
SUMMIT NURSING HOME	CATONSVILLE	BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND	BALTIMORE	CATONSVILLE	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
409 WHEATON PLACE APT. F	21228	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		EXECUTIVE SECRETARY	HESS SHOE COMPANY

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
IRVIN V. BURNESS	MARY F. FITZPATRICK

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JAMES SCHEPF SR.	8990 FT. SMALLWOOD ROAD, PASADENA, MD. 21122

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	LOUDON PARK CEMETERY	BALTIMORE, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Russell Craig Witzke Jr	LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARCINOma of BLADDER & Metastasis	1yr.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Cardiovascular DISEASE

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
J. Nelson McKay MD	D06893	▶ Sept 14, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
413 Commonwealth Ave, Balto. MD 21228

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 14 1989	Gilda Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24681

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOROTHEA M. BENFER			2. DATE OF DEATH (Month, Day, Year): 09 / 12 / 89	3. TIME OF DEATH: 7:40 A M
4. SOCIAL SECURITY NUMBER: 219-23-4037	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 04-10-00	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): MERIDIAN / HAMILTON		9b. CITY, TOWN OR LOCATION OF DEATH: BALTO. MD.		9c. COUNTY OF DEATH: BALTO. CITY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: WOODLAWN	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1408 DORCHESTER AVENUE		10f. ZIP CODE: 21207	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): ADOLPH H. PICK		18. MOTHER'S NAME (First, Middle, Maiden Surname): IDA MERIAM RITTER	
19a. INFORMANT'S NAME (Type/Print): RUDOLPH BENFER JR.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 204 B TIMBER TRAIL, BELAIR, MARYLAND 21014	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. OLIVE CEMETERY	20c. LOCATION — City or Town, State: RANDALLSTOWN, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Russell Witzke		22. NAME AND ADDRESS OF FACILITY: LEORY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cerebrovascular Accident	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atrial Fibrillation

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: C. Vergara-Soares, M.D.	29c. LICENSE NUMBER: D16619	29d. DATE SIGNED (Month, Day, Year): 9/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 100 N. BROADWAY BALTIMORE, MD. 21231 C. VERGARA-SOARES M.D.		
31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24682

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use at the burial permit.
Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES S BECK			2. DATE OF DEATH (Month, Day, Year): 09 10 89	3. TIME OF DEATH: 0906 PM M
4. SOCIAL SECURITY NUMBER: 216 01 9965	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 14, 1912	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Pasadena		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 233 Glen Rd.		10f. ZIP CODE: 21122		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1942 - 1946 WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specity Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed	16b. KIND OF BUSINESS/INDUSTRY: Hardwood Floor Company		
17. FATHER'S NAME (First, Middle, Last): William Jonas Beck		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret H. Schaeffer		
19a. INFORMANT'S NAME (Type/Print): Jean N. Beck	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 233 Glen Rd., Pasadena, Maryland 21122			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Glen Haven Memorial Park	20c. LOCATION — City or Town, State: Glen Burnie, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen D. Schumann	22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, MD 21122			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. AS Hy	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. arter sclerosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHF, Renal Failure, cardiomegaly cardiac arythmia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jorge B Ramirez	29c. LICENSE NUMBER: D0 9596	29d. DATE SIGNED (Month, Day, Year) ▶ 9/11/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JORGE B. RAMIREZ, M.D. 7845 OAKWOOD ROAD, SUITE 205 GLEN BURNIE, MARYLAND 21061		
31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24683

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLARISSA G. COLIE
2. DATE OF DEATH (Month, Day, Year): 8 23 89
3. TIME OF DEATH: 6:50 A M
4. SOCIAL SECURITY NUMBER: 443-05-4089
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): April 23, 1919
8. BIRTHPLACE (State or Foreign Country): Kansas
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Shadyside
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1311 Avalon Boulevard
10f. ZIP CODE: 20764
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): (12) — College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mobile Home Sales Dealer
16b. KIND OF BUSINESS/INDUSTRY: Own Business
17. FATHER'S NAME (First, Middle, Last): Clarence --- Glaser
18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown
19a. INFORMANT'S NAME (Type/Print): GAry Colie
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1311 Avalon Blvd., Shadyside, Maryland 20764
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Union Cemetery
20c. LOCATION — City or Town, State: Burtonsville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard A. Coleman
22. NAME AND ADDRESS OF FACILITY: Richard A. Coleman Funeral Home, Upper Marlboro, Maryland 20772

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPSIS	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ACUTE RIGHT LOWER LOBE PNEUMONIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. ACUTE RESPIRATORY FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. CONGESTIVE HEART FAILURE	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE; CHRONIC ORGANIC BRAIN SYNDROME, DEMENTIA; CARDIOMEGALY

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 8 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Daniel J Ries MD
29c. LICENSE NUMBER: 10C
29d. DATE SIGNED (Month, Day, Year): ▶ 8/23/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DANIEL J RIES HARBOR HOSPITAL
31. DATE FILED (Month, Day, Year): SEP 14 1989
32. REGISTRAR'S SIGNATURE: Gloria Lean Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24684
REG. NO.

12

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HUBERT JOSEPH CHADIMA			2. DATE OF DEATH (Month, Day, Year): 09/12/89	3. TIME OF DEATH: 5:30 p M
4. SOCIAL SECURITY NUMBER: 213-16-6430	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12/10/1920	8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON	9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Timonium	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 55 Oakway Road		10f. ZIP CODE: 21093	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accountant	16b. KIND OF BUSINESS/INDUSTRY: Accounting	
17. FATHER'S NAME (First, Middle, Last): Edward Chadima		18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Huszar		
19a. INFORMANT'S NAME (Type/Print): Mrs. Mary A. Chadima		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 55 Oakway Road Timonium, Maryland 21093		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Mem. Grdns.	20c. LOCATION — City or Town, State: Timonium, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶Bryan W. Clary Bryan W. Clary		22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld Inc. 10 W. Padonia Road Timonium, Md 21093		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CARDIAC ARREST	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	MYOCARDIAL INFARCTION	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Janice L. Miller M.D.		▶ 9/12/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JANICE L MILLER, M.D. G.B.M.C.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 14 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 24685

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use if the ... is not to be filed.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MICHAEL THOMAS DIXON		2. DATE OF DEATH: MONTH 9 DAY 10 YEAR 89	3. TIME OF DEATH: 1255 P M
4. SOCIAL SECURITY NUMBER: 216-52-3928	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 41 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 6/21/48 — 8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD	9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1611 E. CHASE STREET		10f. ZIP CODE: 21213	10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CUSTODIAN	16b. KIND OF BUSINESS/INDUSTRY: POSTAL SERVICE	
17. FATHER'S NAME (First, Middle, Last): SAMPSON DIXON		18. MOTHER'S NAME (First, Middle, Maiden Surname): IRMA JONES	
19a. INFORMANT'S NAME (Type/Print): ARNOLD DIXON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 637 N. AUGUSTA AVENUE/BALTIMORE, MD 21229	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DRUIDRIDGE CEMETERY	20c. LOCATION — City or Town, State: PIKESVILLE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Calvin L. Williams		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. OVERWHELMING SEPSIS	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ENTEROCUTANEOUS FISTULA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. CHRONIC RENAL FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. SMALL BOWEL OBSTRUCTION	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul D. MANOUKIAN, M.D. M.P.H.	29c. LICENSE NUMBER: 92019	29d. DATE SIGNED (Month, Day, Year): ▶ 9/10/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PAUL D. MANOUKIAN, M.D. M.P.H.		
31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24686

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EMILY L. DEWBERRY (EMILY L. DEWBERRY)			2. DATE OF DEATH: MONTH 09 DAY 12 YEAR 89	3. TIME OF DEATH: 2025 M
4. SOCIAL SECURITY NUMBER: 214-14-7500	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6/30/22 (6-30-22)	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: --

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1115 GRANVILLE ROAD		10f. ZIP CODE: 21207	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TELEPHONE OPERATOR	16b. KIND OF BUSINESS/INDUSTRY: A.T.& T.	
17. FATHER'S NAME (First, Middle, Last): ANTON ADAMS		18. MOTHER'S NAME (First, Middle, Maiden Surname): CONSTANCE MESICIVUS	
19a. INFORMANT'S NAME (Type/Print): FRANCIS X. DEWBERRY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1115 GRANVILLE ROAD, BALTIMORE, MARYLAND 21207	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NEW CATHEDRAL CEMETERY	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lawrence Witzke		22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC COLON CANCER	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Juan Herrada M.D. RESIDENT PHYSICIAN	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 9/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JUAN HERRADA, M.D. St Agnes Hospital 900 CATON AVE BALTO MD 21229		
31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Jane Davidson-Randall	

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24687

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elizabeth EAST
2. DATE OF DEATH (Month, Day, Year): 9 - 9 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 215-28-5194
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-1-15
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 533 N. Fulton Ave.
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 533 N. Fulton Ave.
10f. ZIP CODE: 21223
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life, Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Moses FRAZier
16. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Scott
19a. INFORMANT'S NAME (Type/Print): Mrs. Nedra East-Mills
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3506 Cedardale Rd. Balto. Md. 21215
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem. Park 9-12-89
20c. LOCATION — City or Town, State: Balto. Co. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ
22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary Pneumonia — DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ____ DUE TO (OR AS A CONSEQUENCE OF):

c. ____ DUE TO (OR AS A CONSEQUENCE OF):

d. ____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael P. Zimring
29c. LICENSE NUMBER: 015460
29d. DATE SIGNED (Month, Day, Year): ▶ 9/11/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mary Agar
MICHAEL P. ZIMRING, M.D., P.A.
333 ST. PAUL PLACE
BALTIMORE, MD. 21202
332-1616

31. DATE FILED (Month, Day, Year): SEP 14 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24688

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) EDWARD GORMAN EVEREST. Edward Gorman EVEREST, Everest		2. DATE OF DEATH MONTH 09 DAY 11 YEAR 89	3. TIME OF DEATH 0546 M
4. SOCIAL SECURITY NUMBER 213-09-6230	5. SEX 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday) 86 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) 05-08-03
8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital	9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	9c. COUNTY OF DEATH -----	

RESIDENCE OF DECEDENT

10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Catonsville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10a. STREET AND NUMBER 74 Mellor Avenue	10f. ZIP CODE 21228	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES 1922 - 1925	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Textile Worker	16b. KIND OF BUSINESS/INDUSTRY Textile Mill	
17. FATHER'S NAME (First, Middle, Last) Robert William Everest	18. MOTHER'S NAME (First, Middle, Maiden Surname) Ellen Suzanna Harris		
19a. INFORMANT'S NAME (Type/Print) Ramona E. Martin	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 74 Mellor Avenue, Catonsville, MD 21228		
20a. METHOD OF DISPOSITION 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Mem. Park	20c. LOCATION — City or Town, State Elkridge, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb	22. NAME AND ADDRESS OF FACILITY MacNabb Funeral Home 301 Frederick Road, Catonsville, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. FOREIGN Body obstruction, upper airway 2°	9/10/89 9:30 PM
DUE TO (OR AS A CONSEQUENCE OF):	b. Respiratory arrest, Brain anoxia.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF):	Massive GI bleeding 2° to clotting abnormality	
	d. suspected Esophageal varices Hx of alcoholism	9/11/89 5:45 PM

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

COPD
IDDM.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [/] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [/] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [/] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
		9/11/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
St Agnes Hosp. 900 Caton Ave. Balt. MD 21229.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 14 1989	

OHMH-16 Rev 1/89

89 24689

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Josephine Fowler.
2. DATE OF DEATH (Month, Day, Year): 9-13-89
3. TIME OF DEATH: 2:30 P M
4. SOCIAL SECURITY NUMBER: 212-07-3881
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-04-04
8. BIRTHPLACE (State or Foreign Country): Md

RESIDENCE OF DECEDENT

9a. FACILITY NAME (If not institution, give street and number): MPL/FSK Eastern Ave
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:
10a. STATE: Md.
10b. COUNTY: Baltimore Co.
10c. CITY, TOWN OR LOCATION: Parkville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8605 Oakleigh Road
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine Operator
16b. KIND OF BUSINESS/INDUSTRY: Paper Boxes
17. FATHER'S NAME (First, Middle, Last): Unknown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary
19a. INFORMANT'S NAME (Type/Print): Winfield J. Fowler
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8605 Oakleigh Road Baltimore, Maryland 21234
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Redeemer Cemetery
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William E. Johnson
22. NAME AND ADDRESS OF FACILITY: William E. Johnson Funeral Home, P.A. 8521 Loch Raven Blvd. Towson, MD 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Strokes
DUE TO (OR AS A CONSEQUENCE OF):
c. Parkinsonism
DUE TO (OR AS A CONSEQUENCE OF):
d. Stage II Sacral Pressure Sore

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Leaking GTT - Chronic UTI

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, end dus to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: W. S. [illegible] MD
29c. LICENSE NUMBER: D043833
29d. DATE SIGNED (Month, Day, Year): 9/13/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] Eastern Ave Baltimore, Md. 21224
31. DATE FILED (Month, Day, Year): SEP 14 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24690

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Benjamin Foster			2. DATE OF DEATH (Month, Day, Year): 9-5-89		3. TIME OF DEATH: 5:05AM M
4. SOCIAL SECURITY NUMBER: 577-76-4686	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 31 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 31, 1958
8. BIRTHPLACE (State or Foreign Country): Wash. DC					
9a. FACILITY NAME (If not institution, give street and number): 4107 Southern Avenue	9b. CITY, TOWN OR LOCATION OF DEATH: Capital Heights	9c. COUNTY OF DEATH: Prince Georges Co.			

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Capital Heights	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 4107 Southern Avenue #202	10f. ZIP CODE: 20743	10g. CITIZEN OF WHAT COUNTRY? U.S.	

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: American	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Drivers Asst.	16b. KIND OF BUSINESS/INDUSTRY: Gov't. Printing Off.	
17. FATHER'S NAME (First, Middle, Last): Frank A. Foster	18. MOTHER'S NAME (First, Middle, Maiden Surname): Marjorie Gross		
19a. INFORMANT'S NAME (Type/Print): Nadine Foster (wife)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5822 Galloway Place, Oxon Hill, Maryland 20745		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cheltenhem Veterans Cemetery	20c. LOCATION — City or Town, State: Cheltenhem, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Robert G. Mason Funeral Home, Inc.- 1661 Good Hope Road, SE, Wash. DC 20020		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one ceuse on each lina.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Ligature strangulation	
	DUE TO (OR AS A CONSEQUEHCE OF):	
Sequentielly list conditions, if any, leeding to immediete ceuse. Enter UNDERLYING CAUSE (Diseese or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A COHSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ HO	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMIHER? 1 XX YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 XX Residence 6 ☐ Other (Specify)	

27. MAHHER OF DEATH: 1 ☐ Natural 2 ☐ Accident XXX Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF IHJURY (Month, Day, Year): unknown	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 XX NO	28d. OESCRIBE HOW INJURY OCCURED: Subject hanged self
	28e. PLACE OF IHJURY — At home, farm, street, factory, office building, etc. (Specify): home			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 4107 Southern Avenue, Capital Heights, Prince Georges Co. MD

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMIHER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE HUMBER: OCME	29d. DATE SIGNEO (Month, Day, Year): 9-5-89
30. NAME AND ADDRESS OF PERSOH WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan, M.D. 111 Penn Street, Baltimore, MD 21201 VC		
31. DATE FILEO (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24691 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Stewart AKA STUART Griffin			2. DATE OF DEATH Month 9-6-89 Day Year	3. TIME OF DEATH 7:10PM M
4. SOCIAL SECURITY NUMBER 218-92-9426	5. SEX 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday) 17 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 5-31-72	8. BIRTHPLACE (State or Foreign Country) Baltimore, Md
9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE Maryland	10b. COUNTY	10c. CITY, TOWN OR LOCATION Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER 2942 Garrison Blvd.		10f. ZIP CODE 21216	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Food Handler	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Charles Alfred Griffin		18. MOTHER'S NAME (First, Middle, Maiden Surname) Teena Smothers	
19a. INFORMANT'S NAME (Type/Print) Mrs. Teena McGowens	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2942 Garrison Blvd Balto. Md. 21216		
20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Mem Park	20c. LOCATION — City or Town, State Balto. Co. Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ	22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2032 W. North Ave. Balto. Md 21216		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gunshot wound of head	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
XXX 1 ☐ YES 2 ☐ NO	XXX 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 XXX ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 XXX Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) 9-6-89	28b. TIME OF INJURY 6:40PM	28c. INJURY AT WORK? 1 ☐ YES XXX 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED Subject shot
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) house			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2918 Garrison Blvd., Baltimore City, Maryland

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	OCME	▶ 9-6-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles P. Kokes, M.D. 111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 14 1989	Erika Davidson-Randall

DNMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24692

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Stewart Holley				2. DATE OF DEATH (Month, Day, Year): 9 12 89	3. TIME OF DEATH: 6 AM
4. SOCIAL SECURITY NUMBER: 247-03-2833	5. SEX: 1 M 2 F	6. AGE (In yrs. last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 04-15-12	8. BIRTHPLACE (State or Foreign Country): SC
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN COURT NURSING CNTR.		9b. CITY, TOWN OR LOCATION OF DEATH: BALTO, MD 21201		9c. COUNTY OF DEATH	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 X YES 2 NO
10e. STREET AND NUMBER: 11 W. 20th STREET APT 9G		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 Never Married 2 ✓ Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO. IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PIPE LOADER	16b. KIND OF BUSINESS/INDUSTRY: BETHLEHEM STEEL	
17. FATHER'S NAME (First, Middle, Last): JERRY HOLLEY		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY LIGHTING	
19a. INFORMANT'S NAME (Type/Print): CELIA HOLLEY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11W. 20TH STREET APT 9G/BALTIMORE, MD 21218	
20a. METHOD OF DISPOSITION: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE, MD	20c. LOCATION — City or Town, State: 21202	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F?H 1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD — DUE TO (OR AS A CONSEQUENCE OF): — Yrs

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. — DUE TO (OR AS A CONSEQUENCE OF):

c. — DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE

	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 ✓ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ✓ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 ✓ Nursing Home 5 Residence 6 Other (Specify)	
27. MANNER OF DEATH: 1 ✓ Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 YES 2 NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ✓ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D-10268	29d. DATE SIGNED (Month, Day, Year): ▶09-17-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD TYSON, MD., 936 W. NORTH AV., BALTO MD 21217		
31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24693

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NATHANIEL HILL				2. DATE OF DEATH: MONTH 9 DAY 12 YEAR 89	3. TIME OF DEATH: 735 PM
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☐ M 2 ☐ F	6. AGE (In yrs. last birthday): 20 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2 24 1969	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT					
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3020 Windsor Avenue		10f. ZIP CODE: 21216		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Roofer		16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Nathaniel Hill, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Theresa Johnson			
19a. INFORMANT'S NAME (Type/Print): Mrs. Theresa Hill		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3020 Windsor Avenue, Balto., MD 21216			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park		20c. LOCATION — City or Town, State: Balto. Co., MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ		22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home, 2222-26 West North Avenue, Balto., MD 21216			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIAC ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. SEPSIS
DUE TO (OR AS A CONSEQUENCE OF):
c. Endocarditis
DUE TO (OR AS A CONSEQUENCE OF):
d. Renal failure.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pulmonary Compromise
Metabolic Acidosis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☒ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 8/27/89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 9/12/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARK EISNER LIBERTY MED CTR BALT MD

31. DATE FILED (Month, Day, Year): SEP 14 1989 | 32. REGISTRAR'S SIGNATURE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24694
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Nathaniel M. Hawthorne				2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 8 - 1989	3. TIME OF DEATH: 7:45 P.M
4. SOCIAL SECURITY NUMBER: 215 28 6195	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 57 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12/17/31	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md.		9c. COUNTY OF DEATH: none

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 300 Edsdale Rd.		10f. ZIP CODE: 21229	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver	16b. KIND OF BUSINESS/INDUSTRY: Trucking
17. FATHER'S NAME (First, Middle, Last): Johnnie Hawthorne		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa Lee Winfield	
19a. INFORMANT'S NAME (Type/Print): Ellen Johnson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 Edsdale Rd. Balto., Md. 21229	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Auburn	20c. LOCATION — City or Town, State: Balto., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton		22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ACUTE MYOCARDIAL INFARCTION	1-2 HRS.
DUE TO (OR AS A CONSEQUENCE OF):	b. ACUTE CORONARY ARTERY OCCLUSION	
DUE TO (OR AS A CONSEQUENCE OF):	c. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
DUE TO (OR AS A CONSEQUENCE OF):	d.	

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph D. Notarangelo M.D.	29c. LICENSE NUMBER: D 07316	29d. DATE SIGNED (Month, Day, Year): SEPT. 11-1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH D. NOTARANGELO M.D. 301 ST. PAUL PLACE - BALTIMORE MD 21202		
31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24695

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Luvenia Ida Hall			2. DATE OF DEATH: Month September, Day 11, Year 1989	3. TIME OF DEATH: 945 P M
4. SOCIAL SECURITY NUMBER: 222-10-1479	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 86 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 9/29/1902	8. BIRTHPLACE (State or Foreign Country): Whaleysville, MD.
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MARYLAND		9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Worcester	10c. CITY, TOWN OR LOCATION: Berlin	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Beaverdam Creek Road, Rt. 3 Box 554		10f. ZIP CODE: 21811	10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife	16b. KIND OF BUSINESS/INDUSTRY: - - -	
17. FATHER'S NAME (First, Middle, Last): George B. Donoway		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Jane Littleton	
19a. INFORMANT'S NAME (Type/Print): Vergie M. Baker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Truitt St., Box 11A, Willards, Md. 21874	
20a. METNOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Riverside Cemetery	20c. LOCATION — City or Town, State: Libertytown, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard T. Watson		22. NAME AND ADDRESS OF FACILITY: Watson Funeral Home, Inc. Millsboro, Delaware 19966	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar tha mode of dying, such ss cardiac or respiratory arrest, shock, or hsert failure. List only ona cause on aach line.

Approximata Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D 34768	29d. DATE SIGNED (Month, Day, Year): ▶ 9/11/89
30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print): Jeffrey Wieland		
31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMN-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24696

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna L. Johnson (Thompson)			2. DATE OF DEATH (Month, Day, Year): 9-11-89	3. TIME OF DEATH: 4:08PM M
4. SOCIAL SECURITY NUMBER: 066-10-5730	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8/17/20	8. BIRTHPLACE (State or Foreign Country): FLORENCE, SC
9a. FACILITY NAME (If not institution, give street and number): 533 E. 23rd. Street		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 533 E. 23rd STREET		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRESSER/ HOUSEKEEPER	16b. KIND OF BUSINESS/INDUSTRY: LAUNDRY/HOSPITAL	
17. FATHER'S NAME (First, Middle, Last): GEORGE JOHNSON		18. MOTHER'S NAME (First, Middle, Maiden Surname): ALEASE OLIVER	
19a. INFORMANT'S NAME (Type/Print): LEVI JOHNSON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 425 E. 28th STREET/BALTIMORE, MD 21218	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR CEMETERY	20c. LOCATION — City or Town, State: CATONSVILLE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin L. Williams		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Chronic obstructive pulmonary disease, arteriosclerotic XXXX

ITEMS:20b,20c per FH G-659
1-16-90 md

89 24697

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT JONES			2. DATE OF DEATH (Month / Day / Year): 09 / 08 / 89	3. TIME OF DEATH: 10 05 A M
4. SOCIAL SECURITY NUMBER: 217-05-5477	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 99 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 01-23 189[illegible]	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTRE		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE City	9c. COUNTY OF DEATH: -	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3311 Roslyn Ave.		10f. ZIP CODE: 21216	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WWI	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Ellis Jones	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ada Fox

19a. INFORMANT'S NAME (Type/Print): Mr. Lewis Tolson	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3509 Springdale Ave. Balto. Md. 2124

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Cemetery	20c. LOCATION — City or Town, State: Owings Mills, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ	22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 2222 N. North Ave Balto. Md. 2124

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PNUEMONIA with SEPSIS	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. MULTIPLE DECUBITUS ULCERS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. POSSIBLE OSTEOMYELITIS L. HIP	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

- HYPERTENSION.
- ORGANIC BRAIN SYNDROME

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD.	29c. LICENSE NUMBER: D 23300	29d. DATE SIGNED (Month, Day, Year): ▶ 9·8·89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SUDHIR. D. PATEL, Liberty Medical Centre - BALTO. MD.

31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24698 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALBERT JACKSON				2. DATE OF DEATH (Month / Day / Year): 09 / 08 / 89	3. TIME OF DEATH: 11:25 M
4. SOCIAL SECURITY NUMBER: 217070238	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 01/18/05	8. BIRTHPLACE (State or Foreign Country): STATESFIELD, NC
9a. FACILITY NAME (If not institution, give street and number): VA MEDICAL CENTER, FORT HOWARD			9b. CITY, TOWN OR LOCATION OF DEATH: FORT HOWARD		9c. COUNTY OF DEATH: BALTIMORE
RESIDENCE OF DECEDENT					
10a. STATE: MD	10b. COUNTY: BALTIMORE CITY		10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3101 CLIFTON AVE. BALTIMORE, MARYLAND			10f. ZIP CODE: 21216		10g. CITIZEN OF WHAT COUNTRY?: U.S.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: 1941-1943		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CRANE OPERATOR		16b. KIND OF BUSINESS/INDUSTRY: BETH. STEEL
17. FATHER'S NAME (First, Middle, Last): WILLIAM JACKSON			18. MOTHER'S NAME (First, Middle, Maiden Surname): MAGGIE HUGGINS JACKSON		
19a. INFORMANT'S NAME (Type/Print): Mrs. Florence Taylor			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3101 Clifton Ave. Balto. Md. 21216		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Lawn Cem.		20c. LOCATION — City or Town, State: Balto. Co. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ			22. NAME AND ADDRESS OF FACILITY: JOSEPH L. RUSS FUNERAL HOME, INC. 22 W. NORTH AVENUE, BALTIMORE, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. BRONCH. PNEUMONIA	2 Days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CVA, LEFT HEMIPLEGIA	6 Years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. CONGESTIVE HEART FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL INSUFFICIENCY

S/P LAMINECTORY FOR LUMBER SPINES

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Wen-Shyang Wu MD

29c. LICENSE NUMBER: D205088

29d. DATE SIGNED (Month, Day, Year): 09-08-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WEN-SHYANG WU, M.D.

31. DATE FILED (Month, Day, Year): SEP 14 1989

32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randell

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24699 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

07/25/30 TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH JOHNSON			2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 12, 1989	3. TIME OF DEATH: 7:15A M
4. SOCIAL SECURITY NUMBER: 212-26-2221	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 59 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7 26 30	8. BIRTHPLACE (State or Foreign Country): MD

9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: —	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2614 E. CHASE ST		10f. ZIP CODE: 21213	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: KOREAN	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12	College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABOR	16b. KIND OF BUSINESS/INDUSTRY: TRUCK DRIVER

17. FATHER'S NAME (First, Middle, Last): WALTER JOHNSON	18. MOTHER'S NAME (First, Middle, Maiden Surname): FANNY BOLDEN
19a. INFORMANT'S NAME (Type/Print): JO ANN JACKSON	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2614 E. CHASE St BALTO MD 21213

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALT. NATIONAL CEM	20c. LOCATION — City or Town, State: BALTO. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Betts Funeral Home	22. NAME AND ADDRESS OF FACILITY: 1129 N. CAROLINE ST. BALTO MD 21213	

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Lung Cancer	1 year
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Sepsis	1 day
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Cardiac Arrhythmia	1 day
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Earl Hope MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 9/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Earl Hope Johns Hopkins Hospital Baltimore Maryland		
31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24700

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Howard Milton Kern, Jr. M.D.				2. DATE OF DEATH (Month, Day, Year) 9-12-89		3. TIME OF DEATH 12 noon
HOWARD	KERN			09	12	89
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
052 22 8609	1 ☒ M 2 ☐ F	64 YRS.			08-13-25	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Stella Maris Hospice	Towson, MD	Baltimore County

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Baltimore	Towson	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
204 E. Joppa Road Apt #1110	21204	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☒ YES 2 ☐ NO — Korean	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	5 +	Medical Doctor	Medicine

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Howard Kern, Sr.	Henriette Ries

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Paris H. Kern-Winzenburg	4219 Long Green Road, Glen Arm, MD 21057

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metro Crematory, Inc.	Baltimore, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ George E. MacNabb	Cremation Society of MD 299 Frederick Rd., Balto., MD 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Melanoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) Hospice

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Carla S. Alexander M.D.	D27087	▶ 09 12 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Carla S. Alexander, M.D. - 2300 Dulaney Valley Rd. - Towson, MD 21204

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 14 1989	Zeba Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-24701

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Revelle L. LeVine — Revelle Lehe LeVine
2. DATE OF DEATH (Month, Day, Year): 9 12 89
3. TIME OF DEATH: 300 PM
4. SOCIAL SECURITY NUMBER: 477-01-8221
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-14-09
8. BIRTHPLACE (State or Foreign Country): Russia
9a. FACILITY NAME (If not institution, give street and number): Fairland Reg. Ctr
9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Takoma Park
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 7051 Carroll Avenue
10f. ZIP CODE: 20912
10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES XX
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 2 years
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Jewelry
16b. KIND OF BUSINESS/INDUSTRY: Buyer
17. FATHER'S NAME (First, Middle, Last): Harry Kuris
18. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Sussel
19a. INFORMANT'S NAME (Type/Print): Marshall D. LeVine
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 North Chester Street, Baltimore, Maryland 21231
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King David Memorial Garden
20c. LOCATION — City or Town, State: Falls Church, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald M. Stein
22. NAME AND ADDRESS OF FACILITY: DONALD M.STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cerebrovascular accident
Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED: N/A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D24997 (MD)
29d. DATE SIGNED (Month, Day, Year): ▶ 9/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LUIS A. CASAS MD 8317 CHERRY LA. LAUREL MD 20707
31. DATE FILED (Month, Day, Year): SEP 14 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Kelly

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24702

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician for use as the medical record. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM LOWERY
2. DATE OF DEATH (Month, Day, Year): 09-08-89
3. TIME OF DEATH: 1:15 p M
4. SOCIAL SECURITY NUMBER: 247 05 0594
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-09-14
8. BIRTHPLACE (State or Foreign Country): SOUTH CAROLINA
9a. FACILITY NAME (If not institution, give street and number): VA MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: FT. HOWARD
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 920 N. BENTALOW STREET
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ___ College (1-4 or 5+): ___
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Henry Avery Lowery
18. MOTHER'S NAME (First, Middle, Maiden Surname): PEARL BLACK
19a. INFORMANT'S NAME (Type/Print): William Lowery
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 920 N. Bentalow St. Balto. Md. 21216 — CLINICAL RECORDS, VA MEDICAL CENTER, FT HOWARD, MARYLAND 21052
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify): ___
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Mem
20c. LOCATION — City or Town, State: Balto. Co. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ
22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 3222 W. North Ave. Balto. Md. 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	VENTRICULAR FIBRILLATION	minutes
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	ARTERIOSCLEROTIC HEART DISEASE	YEARS
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CEREBROVASCULAR ACCIDENT

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Hyman
29c. LICENSE NUMBER: D37242
29d. DATE SIGNED (Month, Day, Year): ▶
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):
31. DATE FILED (Month, Day, Year): SEP 14 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-1S Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24703 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dorothy Adele Limbert			2. DATE OF DEATH (Month, Day, Year): Sept. 10, 1989	3. TIME OF DEATH: 2:45 P M
4. SOCIAL SECURITY NUMBER: 577-50-9485	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 04-08-12	8. BIRTHPLACE (State or Foreign Country): Indiana
9a. FACILITY NAME (If not institution, give street and number): Harper House, 111 Hamlet Hill Rd.		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: ---	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: ---	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 111 Hamlet Hill Rd., Harper House Apt. 611		10f. ZIP CODE: 21210	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Social Worker	16b. KIND OF BUSINESS/INDUSTRY: Social Service Agency
17. FATHER'S NAME (First, Middle, Last): William Feingold		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Feldman	
19a. INFORMANT'S NAME (Type/Print): Lois L. Witt		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5310 Moorland Ln. Bethesda, MD 20814	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc.	20c. LOCATION — City or Town, State: Baltimore, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George E. MacNabb		22. NAME AND ADDRESS OF FACILITY: Cremation Society of Md., Inc. 299 Frederick Road Balto., MD 21228	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Vaginal Hemmorhage. DUE TO (OR AS A CONSEQUENCE OF):	6 wks.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. metastic Cancer of the lung. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☑ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Nancy Nichols MD	29c. LICENSE NUMBER: D14071	29d. DATE SIGNED (Month, Day, Year): ▶ 9/10/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Nancy Nichols MD 17 Cross Keys Road Baltimore Md. 21210

31. DATE FILED (Month, Day, Year): 9/10/89 SEP 14 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

2

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24704

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HELEN G QUEEN			2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 6, 1989	3. TIME OF DEATH: 4:55 P M
4. SOCIAL SECURITY NUMBER: 216-24-4848	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-24-1928	8. BIRTHPLACE (State or Foreign Country): Balto. Md.
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 807 Exter Hall Ave.		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY? U.S.A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): James Hughes Sr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Christain	
19a. INFORMANT'S NAME (Type/Print): Mr. Bryon & Mr. William Queen	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT I Box 213D Hodgeville S.C. 29927	
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crownsville VA. Cem. 9-11-89	20c. LOCATION — City or Town, State: A.A. Co. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ	22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 2222-24 W. North Ave. Balto. Md 21216	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Lung Cancer DUE TO (OR AS A CONSEQUENCE OF):	1 year.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b.	Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF):	72 hours
c.	DUE TO (OR AS A CONSEQUENCE OF):	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: E Chandri, MD	29c. LICENSE NUMBER: E9866	29d. DATE SIGNED (Month, Day, Year): 9/6/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Eirum Chandri Johns Hopkins Hospital		
31. DATE FILED (Month, Day, Year): SEP 7 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Mendez	

DHMH-16 Rev 1/89

QUEEN, HELEN G F 08/24/28 DMC

Y OL 88 920 0 2M

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24705

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PAVEL ROSPUTKO					2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 13, 1989	3. TIME OF DEATH: 5:45 P M	
4. SOCIAL SECURITY NUMBER: 195-44-7700	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 37 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5-25-1952	8. BIRTHPLACE (State or Foreign Country): BRAZIL	
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY			9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE: Penn	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Philadelphia				10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 5818 New Town Ave Phil.		10f. ZIP CODE: 19120		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.			
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic		16b. KIND OF BUSINESS/INDUSTRY: Auto body Repair			
17. FATHER'S NAME (First, Middle, Last): Wiaghes law Rosputko		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Cyvulyk					
19a. INFORMANT'S NAME (Type/Print): Anna Rosputko		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8234 Bustleton Ave. Phil. Pa. 19111					
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Andrews AKA. Oath.		20c. LOCATION — City or Town, State: S. Bound brook N.J.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mark A. Chojnacki		22. NAME AND ADDRESS OF FACILITY: MARK A. CHOJNACKI 1800 Eliamband St. Balto, Md 21231					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pulmonary edema	2 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	acute Renal failure	2 weeks
DUE TO (OR AS A CONSEQUENCE OF):		
c.	hepatic failure	2 months
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Allogeneic Bone Marrow Transplantation & Chronic Graft vs. Host Disease Chronic Myelogenous Leukemia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

25a. DATE OF INJURY (Month, Day, Year)	25b. TIME OF INJURY M	25c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	25d. DESCRIBE HOW INJURY OCCURED

25e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

25f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Gregory Kuhnemund MD	D38494	▶ 9/13/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GREGORY KUHNEMUND MD 600 N. WOLFE BALTIMORE, MD 21205

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 14 1989	Julia Davidson-Randall

DNMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24706

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GRETA LAIN SHARP					2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 12 1989	3. TIME OF DEATH: 11:25 AM
4. SOCIAL SECURITY NUMBER: 233-48-1501	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 54 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11-07-34	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): NIH, THE CLINICAL CENTER			9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA		9c. COUNTY OF DEATH: MONTGOMERY	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: CHEVY CHASE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3512 BRADLEY LANE		10f. ZIP CODE: 20815	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 6	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: Elementary SChool

17. FATHER'S NAME (First, Middle, Last): Max Horne	18. MOTHER'S NAME (First, Middle, Maiden Surname): Jean Goodstein
19a. INFORMANT'S NAME (Type/Print): MR. DEAN SHARP	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS DECEASED

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King David Memorial Garden	20c. LOCATION — City or Town, State: Falls Church,Va.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: Ives-Pearson Funeral Homes Falls Church, Virginia 22046	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MULTI-SYSTEM ORGAN FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. KLEBSIELLA PNEUMONIAE PNEUMONIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. OVARIAN CARCINOMA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Stewart J. Levine MEDICAL STAFF FELLOW	29c. LICENSE NUMBER: NYS 164733-1	29d. DATE SIGNED (Month, Day, Year) ▶ 9/12/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stewart Levine 9000 rockville pike, BETHESDA, MD 20892

31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24707

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dell JOHN SOTH				2. DATE OF DEATH (Month, Day, Year): 9 12 1989	3. TIME OF DEATH: 11:29 A M	
4. SOCIAL SECURITY NUMBER: 213-05-1432	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 4-19-11	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Rossville			9c. COUNTY OF DEATH: Baltimore County	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Essex			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 603 Mace Avenue		10f. ZIP CODE: 21221			10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tavern Owner			16b. KIND OF BUSINESS/INDUSTRY: Self-Employed	
17. FATHER'S NAME (First, Middle, Last): Christian A. Soth		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth N. Gerst				
19a. INFORMANT'S NAME (Type/Print): Edna L. Soth		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 603 Mace Avenue Baltimore, Maryland 21221				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bel Air Memorial Garden			20c. LOCATION — City or Town, State: Harford Co., Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sarah Jane O'Horo		22. NAME AND ADDRESS OF FACILITY: 7401 Belair Rd. Baltimore, Maryland 21236				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial Infarction — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerotic Disease — DUE TO (OR AS A CONSEQUENCE OF):	
	c. Diabetes Mellitus — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: stroke

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Johnson, MD	1	▶ 9-12-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sandra Johnson M D 9000 Franklin Sq. Drive Baltimore 21237

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 14 1989	Julia Davidson-Kendall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24708

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marlyn Joan SHANAHAN			2. DATE OF DEATH (Month, Day, Year): 9 12 1989	3. TIME OF DEATH: 9:30 A M
4. SOCIAL SECURITY NUMBER: 220-34-5028	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 49 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 28, 1939	8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Franklin Sq uare Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Rossville	9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: BAltimore	10c. CITY, TOWN OR LOCATION: Bowleys Quarters	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3505 Glenwood Road	10f. ZIP CODE: 21220	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2yrs.	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): John F. Martin Sr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Eleanor Hammen

19a. INFORMANT'S NAME (Type/Print): Bronson Shanahan	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3505 Glenwood Road Baltimore Md. 21220

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Cemetery	20c. LOCATION — City or Town, State: BAltimore Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Connelly Funeral Home	22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home 300MaceAve. 21221	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinomatosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Small cell cancer, of the lungs, metastatic	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Naubar MD	29c. LICENSE NUMBER: D18326	29d. DATE SIGNED (Month, Day, Year) ▶ 9/12/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Naeem Gauhar M.D. 5400 Old Court Rd. Randallstown, Md. 21133

31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Gutha Davidson-Randall

DHMH-18 Rev 1/89

Items:23 thru 28f per G-655
9-29-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24709

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alton LEE Smith			2. DATE OF DEATH (Month, Day, Year): 9-12-89	3. TIME OF DEATH: 3:53PM M
4. SOCIAL SECURITY NUMBER: 212 60 6850	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 35 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): SEPT 17 1953	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 4502 Fairview Avenue		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4502 FAIRVIEW AVENUE		10f. ZIP CODE: 21216		10g. CITIZEN OF WHAT COUNTRY? U. S. OF A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [XX] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12; College (1-4 or 5 +):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FILE CLERK		16b. KIND OF BUSINESS/INDUSTRY: FEDERAL GOVERNMENT
17. FATHER'S NAME (First, Middle, Last): RICHARD E. SMITH			18. MOTHER'S NAME (First, Middle, Maiden Surname): DORIS VIRGINIA NORRIS	
19a. INFORMANT'S NAME (Type/Print): MRS. DORIS SMITH		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4502 FAIRVIEW AVENUE BALTIMORE, MARYLAND 21216		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. THOMAS CEMETERY 9/16/89		20c. LOCATION — City or Town, State: RANDALLSTOWN, MD. BALTO. CO.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lewis T. Gwynn		22. NAME AND ADDRESS OF FACILITY: LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVE. BALTIMORE, MARYLAND		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. NARCOTIC INTOXICATION & COCAINE USE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? XX YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [XX] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 9-12-89	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: UNKNOWN
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 4502 Fairview Ave. Baltimore, Maryland

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles P. Kokes MD	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 9-13-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn Street, Baltimore, MD 21201 vc

31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24710

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NORA ANN SIEMER			2. DATE OF DEATH (Month, Day, Year): 09 11 89	3. TIME OF DEATH: 0110 PM M
4. SOCIAL SECURITY NUMBER: 212 44 3073	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 46 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 14, 1942	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Pasadena		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 207 Oak Dr.		10f. ZIP CODE: 21122		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Domestic
17. FATHER'S NAME (First, Middle, Last): Bartholomew Feeney		18. MOTHER'S NAME (First, Middle, Maiden Surname): Evelyn Blinke		
19a. INFORMANT'S NAME (Type/Print): Robert H. Siemer, Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 207 Oak Dr., Pasadena, Maryland 21122		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery		20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stefan D. Shumaker		22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, MD 21122		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Basilar Brain Stem CVA	52 hrs
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Respiratory Distress Syndrome/Septic Shock	6 wks
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Perforated Colon Peritonitis	8 wks
DUE TO (OR AS A CONSEQUENCE OF):		
d.	Radiation Colitis	12 yrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: frozen pelvis 2nd Carcinoma

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Constantine J Padussis	29c. LICENSE NUMBER: D18823	29d. DATE SIGNED (Month, Day, Year): ▶ 9/11/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CONSTANTINE J. PADUSSIS, M.D. 7310 RITCHIE HIGHWAY GLEN BURNIE, MARYLAND 21061		
31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24711

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rita R. Stouffer

2. DATE OF DEATH (Month, Day, Year): Sept. 12, 1989

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 216-03-2293

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Mar. 19/1918

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): 1416 Patapsco St.

9b. CITY, TOWN OR LOCATION OF DEATH: Balto. City, Md.

9c. COUNTY OF DEATH: ---------

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: ---------

10c. CITY, TOWN OR LOCATION: Balto. City, Md.

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 1412 Patapsco St.

10f. ZIP CODE: 21230

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th. grade
College (1-4 or 5+): -------

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Catalog

16b. KIND OF BUSINESS/INDUSTRY: Mail Order

17. FATHER'S NAME (First, Middle, Last): John ---- Ross

18. MOTHER'S NAME (First, Middle, Maiden Surname): Stella Unknown

19a. INFORMANT'S NAME (Type/Print): Mr. Paul D. Stouffer

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1416 Patapsco St. Balto. Md. 21230

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Mem. Park

20c. LOCATION — City or Town, State: Elkridge, Howard Co. Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Daniel A. Naylor

22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Metastatic adenocarcinoma

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Deep vein thrombophlebitis of L leg

DUE TO (OR AS A CONSEQUENCE OF):
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD

29c. LICENSE NUMBER: D25654

29d. DATE SIGNED (Month, Day, Year): ▶ 9/14/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1412 Crain Highway N. GB MD 21061

31. DATE FILED (Month, Day, Year): SEP 14 1989

32. REGISTRAR'S SIGNATURE: Judith Baer

DHMH-16 Rev 1/89

1 · FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24712

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUSSELL B SPANGENBERG			2. DATE OF DEATH: 09 MONTH 10 DAY 89 YEAR	3. TIME OF DEATH: 0714 AM M
4. SOCIAL SECURITY NUMBER: 195 01 6426	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 2, 1920	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Pasadena	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [XX] NO
10e. STREET AND NUMBER: Rt. 3 Box 344 (no other address known)		10f. ZIP CODE: 21122	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Butcher	16b. KIND OF BUSINESS/INDUSTRY: Butcher Shop	
17. FATHER'S NAME (First, Middle, Last): Herbert Spangenberg		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth (Unknown)	
19a. INFORMANT'S NAME (Type/Print): Judy White		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Crofton Convalesent Center 2131 Davidsonville Rd., Crofton, MD 21114	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery	20c. LOCATION — City or Town, State: Baltimore, City, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Stephen D. Schumann		22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, MD 21122	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic cardiovascular disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert B Kroopnick MD	29c. LICENSE NUMBER: D17753	29d. DATE SIGNED (Month, Day, Year): 9/11/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT B KROOPNICK, M.D. 95 AQUAHART ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061

31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Esther Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24713

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Jane Snyder			2. DATE OF DEATH (Month, Day, Year): Sept. 11, 1989	3. TIME OF DEATH: 5:30 A M
4. SOCIAL SECURITY NUMBER: 173-05-7974	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10/17/14	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 6101 Emerald Lane 21784		9b. CITY, TOWN OR LOCATION OF DEATH: Sykesville		9c. COUNTY OF DEATH: Carroll
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Sykesville		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6101 Emerald Lane		10f. ZIP CODE: 21784		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bookkeeper		16b. KIND OF BUSINESS/INDUSTRY: Woolworths
17. FATHER'S NAME (First, Middle, Last): James MacFarland			18. MOTHER'S NAME (First, Middle, Maiden Surname): Purnella Uebele	
19a. INFORMANT'S NAME (Type/Print): Robert A. Snyder		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6101 Emerald Lane Sykesville, MD 21784		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc.		20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George E. MacNabb		22. NAME AND ADDRESS OF FACILITY: Cremation Society of Md., Inc. 299 Frederick Road Balto., MD 21228		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Large Cell Carcinoma of the Lung (to Brain)	1½ months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): NOV6	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Arthur J. Lovard MD	29c. LICENSE NUMBER: D 25786	29d. DATE SIGNED (Month, Day, Year): 9/11/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Arthur J. Lovard MD 1102 LIBERTY RD. ELDERSBURG, MD.		
31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24714 — REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Vellis, Vula K.			2. DATE OF DEATH (Month, Day, Year): 9 9 89	3. TIME OF DEATH: 9:30 P M
4. SOCIAL SECURITY NUMBER: 174-03-4159	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): September 14, 1912	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Clinton, MD. 20735		9c. COUNTY OF DEATH: P.G. Prince Georges
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince Georges County	10c. CITY, TOWN OR LOCATION: Clinton		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Pine View Manor, Pine View Road		10f. ZIP CODE: 20735		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Domestic		
17. FATHER'S NAME (First, Middle, Last): Peter Kainaros		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sophia Hasapis		
19a. INFORMANT'S NAME (Type/Print): George Vellis (Son)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 615 3rd. St. N.E., Washington, D.C.		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Trinity Cemetery	20c. LOCATION — City or Town, State: Pittsburg, Pa.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Murphy-Falls Church Funeral Home, 1102 W. Broad St. Falls Church, Va. 22046			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary arrest

DUE TO (OR AS A CONSEQUENCE OF): b. Cerebrovascular accident

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. Dyspnea

DUE TO (OR AS A CONSEQUENCE OF): d. Upper motor neuron paralysis

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURRED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D20853	9/10/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Glen R. Jameson 9450 Penn. Ave #R Upper Marlboro MD 20772

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 14 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 24715

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20+1

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Joseph	Van Collom, Jr.		September 11 1989	M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
218-07-8020	1 ☒ M 2 ☐ F	72 YRS.			July 18 1917	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Greater Balto. Med. Ctr.	Towson	Baltimore

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Baltimore	Timonium	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
321 E. Timonium Road	21093	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☒ YES 2 ☐ NO — WW II	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	Executive Secretary	Balto. City Liquor Board

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Joseph Van Collom, Sr	Grace Worth

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elmira Van Collom	321 E. Timonium Rd., Timonium, Md. 21093

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Dulaney Valley Memorial Gardens	Timonium, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Bryan W. Clary	Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd., Timonium, Md. 21093

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac heart failure	1-2 hours
DUE TO (OR AS A CONSEQUENCE OF):	b. Coronary artery Disease	10 Yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF):	c. Cardiomyopathy	2 yrs.
	d. old myocardial Infarcta	10 yrs.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma Prostate
Sarcadosis – osteoporosis

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ In Patient 2 ☒ ER/Outpatient 3 ☒ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John S. Davis, MD	D02300	▶ 9/13/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
John Davis, M.D. Medical Arts Bldg., Suite 401, Cathedral & Read Streets, Balto., Md.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 14 1989	Gisha Davidson-Randall

DHMH-16 Rev 1/89

ITEM #7 FILM #G657 PER: F. H. 11/06/89 J.A.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24716

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rodney Dale ~~H.~~ Whatley, Jr.			2. DATE OF DEATH (Month, Day, Year): 9-10-89	3. TIME OF DEATH: 7:45PM M
4. SOCIAL SECURITY NUMBER: 217-11-3100	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 17 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): ~~July~~ APRIL 23, 1972	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): University Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Essex	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 947 Middlesex Raod		10f. ZIP CODE: 21221	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Rodney Dale Whatley Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nancy Hayes	
19a. INFORMANT'S NAME (Type/Print): Rodney D. Whatley Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 947 Middlesex Road BAltimore MAryland 21221	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CrestLawn Cemetery	20c. LOCATION — City or Town, State: BAltimore Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home		22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home 300Mace Ave. 21221	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hanging

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO INSPECTION	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home [X] Residence 8 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 9-10-89	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 [ ] YES [X] NO	28d. DESCRIBE HOW INJURY OCCURED: Subject hanged self
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 304 Garnett Road, Baltimore City Maryland

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 9-11-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: John Davidson-Kenedy

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24717

25

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LAURA B. WERTH
2. DATE OF DEATH: MONTH 9 DAY 11 YEAR 89
3. TIME OF DEATH: 11:20 PM
4. SOCIAL SECURITY NUMBER: 524-22-4455
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): APRIL 30, 1904
8. BIRTHPLACE (State or Foreign Country): MISSOURI
9a. FACILITY NAME (If not institution, give street and number): Wilson Health Care Center
9b. CITY, TOWN OR LOCATION OF DEATH: Gaithersburg Md.
9c. COUNTY OF DEATH: Mont.

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: MONTGOMERY
10c. CITY, TOWN OR LOCATION: GAITHERSBURG
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 403 Russell Ave. #602
10f. ZIP CODE: 20877
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TEACHER
16b. KIND OF BUSINESS/INDUSTRY: EDUCATION
17. FATHER'S NAME (First, Middle, Last): MILES ALDEN NICHOLAS
18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH RANKIN JOHNSTON
19a. INFORMANT'S NAME (Type/Print): GWENDOLYN LUTTRELL
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9408 BYEFORDE ROAD KENSINGTON, MD. 20895
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY
20c. LOCATION — City or Town, State: ALEXANDRIA, VA.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Muriel H. Barber
22. NAME AND ADDRESS OF FACILITY: MURIEL H. BARBER FUNERAL HOME 21525 LAYTONSVILLE ROAD LAYTONSVILLE, MD. 20882

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Adenocarcinoma site undetermined	2 mo.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: 07231
29d. DATE SIGNED (Month, Day, Year): ▶ 9-12-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James R. Moore Jr. 207 Brookes Ave Gaithersburg
31. DATE FILED (Month, Day, Year): SEP 14 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

Item #6 per FH 9/15/89 sp

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24718 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hattie Warwick			2. DATE OF DEATH (Month, Day, Year): 09 12 89	3. TIME OF DEATH: 04:05 PM
4. SOCIAL SECURITY NUMBER: 212-28-3339	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): ~~84~~ 85 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6/15/04	8. BIRTHPLACE (State or Foreign Country): NC
9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 11 W. 20TH STREET APT. 5 C		10f. ZIP CODE: 21218		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th; College (1-4 or 5 +):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY: DOMESTIC
17. FATHER'S NAME (First, Middle, Last): HECTOR HARRIS		18. MOTHER'S NAME (First, Middle, Maiden Surname): FANNIE WATSON		
19a. INFORMANT'S NAME (Type/Print): CHARLES KELLEY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 744 EXETER HALL/BALTIMORE, MD 21218		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY		20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Malignant Cardiac Arrhythmia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Atherosclerotic Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Sepsis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Sabah Al-Attar, M.D.	29c. LICENSE NUMBER: D37725	29d. DATE SIGNED (Month, Day, Year): 09/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sabah A. Al-Attar, Liberty Medical Center, Baltimore, MD		
31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Reynolds	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24719 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY KATHLEEN WENTWORTH				2. DATE OF DEATH (Month, Day, Year): Sept 11 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 540.48.1318	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 46 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Mar 11, 1943	8. BIRTHPLACE (State or Foreign Country): California
9a. FACILITY NAME (If not institution, give street and number): Howard County Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Columbia		9c. COUNTY OF DEATH: Howard Co.

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Hanover	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1925 Canonchet Court		10f. ZIP CODE: 21076	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): None	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Clarence Meyer		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Criswald	
19a. INFORMANT'S NAME (Type/Print): Ralph H. Wentworth	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park	20c. LOCATION — City or Town, State: Elkridge, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard B Dawson	22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Neuromuscular/hypoxic respiratory failure	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): diffuse carcinomatosis	2 months
	c. DUE TO (OR AS A CONSEQUENCE OF): lung adeno carcinoma	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
1) cardiac tamponade
2) s/p thoracotomy for pericardiectomy
3) profound axonal neuromuscular disease

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): NA	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURRED: NA
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): NA

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: George S. Groman MD	29c. LICENSE NUMBER: D34385	29d. DATE SIGNED (Month, Day, Year): ▶ 9-12-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GEORGE S GROMAN, 2KNOLL N. DRIVE COLUMBIA MD 21045

31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24720
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Wall SR.			2. DATE OF DEATH (Month, Day, Year): September 12, 1989	3. TIME OF DEATH: 3:30A M
4. SOCIAL SECURITY NUMBER: 218-05-9030	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 15, 1920	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: —	10c. CITY, TOWN OR LOCATION: BALTO.	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 2027 E. Eager St	10f. ZIP CODE: 21205	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Negro

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): (12) College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Labor	16b. KIND OF BUSINESS/INDUSTRY: —

17. FATHER'S NAME (First, Middle, Last): William Wall SR.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Branch
19a. INFORMANT'S NAME (Type/Print): Josephine Jackson	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2027 E. Eager St. Balto. MD 21205

20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest V.E.	20c. LOCATION — City or Town, State: Owings Mills MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Betts Funeral Home	22. NAME AND ADDRESS OF FACILITY: 1129 N. Caroline St.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the [illegible] permit. Pages 1-2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. Metastatic Esophageal Carcinoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 XX NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Yuen	29c. LICENSE NUMBER: n/a	29d. DATE SIGNED (Month, Day, Year): ▶ 9/12/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Monita Yuen, M.D. c/o Maryland General Hospital

31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Linda Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24721

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Audrey C. Willis			2. DATE OF DEATH: MONTH 9 DAY 12 YEAR 89	3. TIME OF DEATH: 9:15 A.M.
4. SOCIAL SECURITY NUMBER: 216-03-5683	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6/30/11	8. BIRTHPLACE (State or Foreign Country): Baltimore, MD
9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice		9b. CITY, TOWN OR LOCATION OF DEATH: Towson, MD		9c. COUNTY OF DEATH: Baltimore County
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3729 Reuckert Avenue		10f. ZIP CODE: 21206		10g. CITIZEN OF WNAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR OATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Ret. Clerical		16b. KIND OF BUSINESS/INDUSTRY: Western Electric	
17. FATHER'S NAME (First, Middle, Last): - Caspare			18. MOTHER'S NAME (First, Middle, Maiden Surname): - -	
19a. INFORMANT'S NAME (Type/Print): Toni Shaney		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4414 Valley View Avenue Baltimore, Md. 21206		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Sept. 15, 1989		20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Gladden James F. Gladden		22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck Inc. 5305 Harford Rd. 21214		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such ee cerdiec or reepiratory errest, shock, or heart fellure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pancreatic Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CASE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. MANNER OF OEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
C Alexander MD	D27087	▶ 9/12/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Carla S. Alexander, M.D. - 2300 Dulaney Valley Rd.- Towson, MD 21204

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 14 1989	Gloria Davidson-Saunders

OHMH-16 Rev 1/89

UNKNOWN 89-165

Items:28C,28F per ME 8-656

10-27-89 cm

89 24722

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Louis Otto Wise, III / Louis / O. / Wise, III			2. DATE OF DEATH: MONTH 9 DAY 11 YEAR 89	3. TIME OF DEATH: 4:17AM M
4. SOCIAL SECURITY NUMBER: 215-74-9520	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 32 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-11-56	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Intersection/Elizabeth Rd/W.Patapsco	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City	9c. COUNTY OF DEATH: -------		

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: -----	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2502 W. Patapsco Avenue, Apt 2D	10f. ZIP CODE: 21230	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Lithographer	16b. KIND OF BUSINESS/INDUSTRY: Lithography
17. FATHER'S NAME (First, Middle, Last): Louis Otto Wise, Jr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Shirley Ann Erwin	
19a. INFORMANT'S NAME (Type/Print): Louis O. Wise, Jr.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 Magruder Avenue, Catonsville, MD 21228	

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc.	20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George E. MacNabb	22. NAME AND ADDRESS OF FACILITY: MacNabb Funeral Home, Catonsville, Maryland 21228	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ee cardiec or reapiratory arreat, shock, or heart failure. List only ona cause on aach line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Shotgun wound of chest; Stabwounds (2) to back of chest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence [X] Other (Specify) scene	

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 9-11-89	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: Subject shot and stabbed
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home & Street 2502 W Patapsco Ave			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Intersection/Elizabeth Rd./ W.Patapsco Ave.,Baltimore City, MD

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 9-11-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Ruth Davidson-Randall

OHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24723
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last): ROBERT A. ABBOTT				2. DATE OF DEATH (Month, Day, Year): August 30, 1989	3. TIME OF DEATH: 9:10 a M
4. SOCIAL SECURITY NUMBER: 705-05-4621	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 03-25-1906	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany
RESIDENCE OF DECEDENT					
10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11512 Bank Avenue - Fairgo		10f. ZIP CODE: 21502		10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist	16b. KIND OF BUSINESS/INDUSTRY: CSX Company			
17. FATHER'S NAME (First, Middle, Last): John Abbott		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Sloan			
19a. INFORMANT'S NAME (Type/Print): Miss Judith A. Abbott	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11512 Bank Avenue, Cumberland, MD 21502				
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Restlawn Memorial Gardens	20c. LOCATION — City or Town, State: LaVale, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Scarpelli	22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, Cumberland, Md 21502				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio - Respiratory Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Advanced Small Cell Lung C	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Bone and liver mets.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D23371	▶ 8/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Zaman, Memorial Hospital Medical Building, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 05 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24724

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN PAIGE ASHENFELTER		2. DATE OF DEATH (Month, Day, Year): August 27, 1989	3. TIME OF DEATH: 8:52 p M
4. SOCIAL SECURITY NUMBER: 214-05-9405	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 93 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 01-28-1896 / 8. BIRTHPLACE (State or Foreign Country): WV
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: Allegany	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 31 Somerville Avenue	10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW I	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): senior clerk	16b. KIND OF BUSINESS/INDUSTRY: Railroad	
17. FATHER'S NAME (First, Middle, Last): Charles Edward Ashenfelter	18. MOTHER'S NAME (First, Middle, Maiden Surname): Isabelle Blackburn		
19a. INFORMANT'S NAME (Type/Print): Ira Charles Ashenfleter Mrs. Phyllis A. Twigg	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 31 Somerville Avenue, Cumberland, MD 21502 LaVale, MD 21502		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Burial Park	20c. LOCATION — City or Town, State: Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Scarpelli	22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. respiratory failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. pneumonia	unk
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mark Sagin MD	29c. LICENSE NUMBER: D35481	29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Sagin, 4th Floor, West, Memorial Hospital, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24725

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
GLADYS	JOSEPHINE	BURKEY	08 24 89	10:25pm M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
214-07-1851	1 ☐ M 2 ☒ F	72 YRS.			7/11/17	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
SACRED HEART HOSPITAL	Cumberland	ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Allegany	LaVale	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
9 Asbury Avenue	21502	U S A

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
10	0	Cafeteria Worker	Food Industry

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Charles Klosterman	Julia Walkoviak

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Richard J. Burkey	7 Oaklawn Ave. LaVale, MD 21502

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Sunset Memorial Park	Cumberland, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Douglas A. Hafer	Hafer Chapel of the Hills Mortuary 1302 National Hwy LaVale, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	48 hrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Carcinomatosis abdominal	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Pancreas Ca c obstruction & mets	15 mos.
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
A.B. Flores MD	DO 1535	▶ 8/20/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. AUDBERTO FLORES 924 SETON DR. CUMBERLAND, MD. 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 28 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24726

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN FRANCIS BOND			2. DATE OF DEATH: MONTH 08 DAY 25 YEAR 89	3. TIME OF DEATH: 11:15 A M
4. SOCIAL SECURITY NUMBER: 217104221	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb.16,1913	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Frostburg		10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 18 Beall St.		10f. ZIP CODE: 21532		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Textile	16b. KIND OF BUSINESS/INDUSTRY: Celanese		
17. FATHER'S NAME (First, Middle, Last): John A. Bond		18. MOTHER'S NAME (First, Middle, Maiden Surname): Hannah J. Moore		
19a. INFORMANT'S NAME (Type/Print): E. Jane Bond	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 Honeysuckle Lane, Frostburg, Md. 21532			
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Frostburg Memorial Park	20c. LOCATION — City or Town, State: Frostburg, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John P. Horn	22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home, Frostburg, Md.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Thrombosis — Hrs

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure, Diabetes, Urinary Infection, Pneumonia

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO N/A

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	N/A	M	1 [ ] YES 2 [ ] NO	N/A
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
for GHB	D25817	8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GEORGE BREZA, M.D. BMG 912 SETON DRIVE CUMBERLAND, MD. 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24727

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Emily R. Boyle			2. DATE OF DEATH (Month / Day / Year): 08/27/89	3. TIME OF DEATH: 12:15 PM
4. SOCIAL SECURITY NUMBER: 194 03 0197	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 01/04/14	8. BIRTHPLACE (State or Foreign Country): Penna.
9a. FACILITY NAME (If not institution, give street and number): Frostburg Community Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg		9c. COUNTY OF DEATH: Allegany
RESIDENCE OF DECEDENT				
10a. STATE: Md	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Frostburg		10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 109 Mt Pleasant St		10f. ZIP CODE: 21532		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housekeeper	16b. KIND OF BUSINESS/INDUSTRY: Church Rectory		
17. FATHER'S NAME (First, Middle, Last): Frank Jesse Miller		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula Belle Eicher		
19a. INFORMANT'S NAME (Type/Print): Joseph E. Boyle	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 209 Daisy Drive, Hagerstown, Md. 21740			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Michaels Cemetery	20c. LOCATION — City or Town, State: Frostburg, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John P. Horn	22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home, Frostburg, Md.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. RESPIRATORY FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ARTERIOSCLEROTIC HEART DISEASE,
CONGESTIVE HEART FAILURE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
S. Chang MD	D25638	▶ 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
S.T.Chang, MD Frostburg Plaza, Frostburg, MD 21532

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

12

Item #23 abcd FilmG656 10/6/89 kam

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24728 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD RAYMOND COPE		2. DATE OF DEATH (Month, Day, Year): August 26, 1989	3. TIME OF DEATH: 10:50 P.M
4. SOCIAL SECURITY NUMBER: 220-16-6310	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-21-1924
8. BIRTHPLACE (State or Foreign Country): MD			
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital & Medical Building	9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: Allegany	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Route 4 Box 295A	10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): police force	16b. KIND OF BUSINESS/INDUSTRY: navale academy/Railroad	
17. FATHER'S NAME (First, Middle, Last): Lewellyn Cope		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Gephart	
19a. INFORMANT'S NAME (Type/Print): M. June Cope		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 4 Box 295A, Cumberland, MD 21502	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Tabor Cemetery	20c. LOCATION — City or Town, State: Oldtown, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. [illegible] Respiratory Arrest		1 YEAR
DUE TO (OR AS A CONSEQUENCE OF): b. EMPHYSEMA		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. [illegible] Cor Pulmonale		
DUE TO (OR AS A CONSEQUENCE OF): d. [illegible] Carcinoma of the Lung, Paraneoplastic Syndrome, respiratory failure, Hypoxemia, Cardiopulmonary cachexia		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D18769	29d. DATE SIGNED (Month, Day, Year): 8/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. James Raver, Memorial Hospital, Cumberland, MD 21502		
31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24729

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOWDEN, CAMILLIA NMI				2. DATE OF DEATH: MONTH 09 DAY 02 YEAR 89	3. TIME OF DEATH: 03:45am M
4. SOCIAL SECURITY NUMBER: 234-38-8620	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 07-26-1925	6. BIRTHPLACE (State or Foreign Country): WV
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: ALLEGANY
RESIDENCE OF DECEDENT					
10a. STATE: WV	10b. COUNTY: Mineral	10c. CITY, TOWN OR LOCATION: Ridgeley			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Route 1 Box 108		10f. ZIP CODE: 26753			10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): owner		16b. KIND OF BUSINESS/INDUSTRY: Restaurant	
17. FATHER'S NAME (First, Middle, Last): Eugene Twigg				16. MOTHER'S NAME (First, Middle, Maiden Surname): Magdeline Lena Logsdon	
19a. INFORMANT'S NAME (Type/Print): Mrs. Valerie J. Greise		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Cumberland, MD 21502			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Ashby Cemetery		20c. LOCATION — City or Town, State: Fort Ashby, WV	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Septic shock	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Hemochromatosis c CHF.	
	c. DUE TO (OR AS A CONSEQUENCE OF): Sideroblastic anemia with	
	d. DUE TO (OR AS A CONSEQUENCE OF): years of transfusion	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 6 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John Mehanna	D-17526	▶ 9-2-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. JOHN MEHANNA 909-B SETON DR. CUMBERLAND, MD. 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 05 1989	Julie Davidson-Randell

10

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24730

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Delores Jean Emerick			2. DATE OF DEATH (Month, Day, Year): 09/01/1989	3. TIME OF DEATH: 01:33 am M
4. SOCIAL SECURITY NUMBER: 220323936	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 53 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 05/31/1936	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Sacred Heart Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany County

RESIDENCE OF DECEDENT

10a. STATE: PA	10b. COUNTY: Somerset	10c. CITY, TOWN OR LOCATION: Hyndman	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: R D 1, Box 388		10f. ZIP CODE: 15545	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Charles Rowe		18. MOTHER'S NAME (First, Middle, Maiden Surname): Vera Mortzfeldt	
19a. INFORMANT'S NAME (Type/Print): Leo M. Emerick		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R D 1, Box 388, Hyndman, PA 15545	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Comps Cemetery	20c. LOCATION — City or Town, State: RD, Hyndman, PA 15545
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harvey H Zeigler		22. NAME AND ADDRESS OF FACILITY: Harvey H. Zeigler Funeral Home Clarence Street, Hyndman, PA 15545	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory failure.	Immediate
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. multiple organ failure (hepatic and renal)	2 weeks
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Sepsis status post gastrojejunostomy	3 weeks
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. pyloric stenosis, metastatic Breast Ca	Long time

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Metastatic Breast carcinoma c pancytopenia.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Sheshara MD	29c. LICENSE NUMBER: D34999	29d. DATE SIGNED (Month, Day, Year): ▶ 9-1-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sheilesh Adeshara, M.D. 924 Seton Drive Cumberland, Md 21502		
31. DATE FILED (Month, Day, Year): SEP 05 1989	32. REGISTRAR'S SIGNATURE: Julie Davidson-Rindella	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24731
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
CHARLES	ERNEST	FLINN	09 / 03 / 89	01:20am M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
217-10-6203	1 [X] M 2 [ ] F	90 YRS.			04-06-1899	England

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
SACRED HEART HOSPITAL	Cumberland	ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Allegany	Cresaptown	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
14900 McMullen Hwy.	21502	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		supervisor	spinning dept./textile

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
George Flinn	Ada Wiltshire

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Helen R. Flinn	14900 McMullen Hwy., Cresaptown, MD 21502

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Zion Memorial Park	Cumberland, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ James F Scarpelli	Scarpelli Funeral Home, Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac failure DUE TO (OR AS A CONSEQUENCE OF):	12 hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF):	15 yr
	c. Carcinoma lung DUE TO (OR AS A CONSEQUENCE OF):	3 yr.
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration
Malnutrition
Cont

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Geo Kay MD	D12532	▶ 9-5-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

BMG 912 SETON DR. CUMBERLAND, MD. 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 05 1989	Julia Davidson-Randall

DHMH-t6 Rev t/89

89 24732

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, & should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLARA ELIZABETH FETTERS			2. DATE OF DEATH (Month, Day, Year): 8-28-89	3. TIME OF DEATH: 8:13P M
4. SOCIAL SECURITY NUMBER: 220037821	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 29, 1906	6. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: ALLEGANY COUNTY

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Corriganville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: P.O.Box 173		10f. ZIP CODE: 21524	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): John C. Bloss		18. MOTHER'S NAME (First, Middle, Maiden Surname): Maude Elizabeth(Twigg) Bloss	
19a. INFORMANT'S NAME (Type/Print): Richard Fetters	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O.Box 312 Ellerslie 21529 MD		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Restlawn Memorial Gardens	20c. LOCATION — City or Town, State: Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ S. Mark Sapp	22. NAME AND ADDRESS OF FACILITY: George-Upchurch Funeral Home, P.A. 202 Greene St. Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. sepsis	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. hydronephrosis	4 wks
	DUE TO (OR AS A CONSEQUENCE OF): c. carcinoma of the bladder	3 mos
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: post of carcinoma of the large intestine

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Donald Manger	29c. LICENSE NUMBER: D09231	29d. DATE SIGNED (Month, Day, Year): ▶ 8 29 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR DONALD MANGER 55 JACKSON ST LONACONING, MD 21539		
31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24733
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
OKLEN	HENRY	GEIGER	August 27, 1989	6:00 A.M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
214-07-4848	1 [X] M 2 [ ] F	77 YRS.			JUNE 19 1912	MARYLAND

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Memorial Hospital	Cumberland	Allegany

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND	ALLEGANY	RFD# 1 BOX# 157 CUMBERLAND	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
BOX# 157 RFD# 1	21502	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		ALLEGANY BALLISTICS LABORATORY	PLANT PROTECTION

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
HENRY THOMAS GEIGER	CATHERINE NICKEL

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GENEVA E. GEIGER	RFD# 1 BOX# 157 CUMBERLAND, MARYLAND 21502

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	REST LAWN MEMORIAL GARDENS	LAVALE MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Dale L. Merritt	SILCOX-MERRITT FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia, Right lower lobe	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Terminal Parkinson's disease

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[illegible]	D14865	▶ 8-30-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. Torres, Memorial HOspital Medical Building, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24734

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George Grindle Sr.			2. DATE OF DEATH (Month, Day, Year): Sept. 1, 1989	3. TIME OF DEATH: 3:00 A. M
4. SOCIAL SECURITY NUMBER: 217-10-6208	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 82 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 19, 1907	8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): 56 West Main St.		9b. CITY, TOWN OR LOCATION OF DEATH: Lonaconing		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Lonaconing	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 56 West Main St.		10f. ZIP CODE: 21539	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cel. Fibers Corp.	16b. KIND OF BUSINESS/INDUSTRY: Textile	
17. FATHER'S NAME (First, Middle, Last): Cornelius Grindle		18. MOTHER'S NAME (First, Middle, Maiden Surname): Flora Hadley	
19a. INFORMANT'S NAME (Type/Print): Mrs. Margaret Grindle		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 56 West Main St, Lonaconing, Md. 21539	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Laurel Hill Cemetery	20c. LOCATION — City or Town, State: Moscow, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James E. McKenzie		22. NAME AND ADDRESS OF FACILITY: Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Adenocarcinoma Prostate, metastatic	years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas J. Devlin MD	29c. LICENSE NUMBER: D21488	29d. DATE SIGNED (Month, Day, Year) ▶ 9-1-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas J. Devlin MD, 55 Jackson St, Lonaconing, Md.		
31. DATE FILED (Month, Day, Year): SEP 05 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

6

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24735

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CECILIA EVA HARDEN
2. DATE OF DEATH: MONTH AUGUST DAY 14 YEAR 1989
3. TIME OF DEATH: 0125 HRS M
4. SOCIAL SECURITY NUMBER: 215 58 6967
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 98 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-05-1890
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Allegany Co. Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND MD
9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: Cumberland
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 724 Greene Street
10f. ZIP CODE: 21502
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): former employee
16b. KIND OF BUSINESS/INDUSTRY: Telephone Co & Dye Works
17. FATHER'S NAME (First, Middle, Last): William Feidt
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Rossworm
19a. INFORMANT'S NAME (Type/Print): Mrs. Ruth H. Geary
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Cumberland, MD 21502
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SS Peter Paul Cemetery
20c. LOCATION — City or Town, State: Cumberland, MD 21502
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli
22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cerebro vascular accident
DUE TO (OR AS A CONSEQUENCE OF):
b. Arteriosclerotic peripheral vascular disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
C.H.F., Organic brain Syndrome

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: V. A. Ranjithan
29c. LICENSE NUMBER: D19 750
29d. DATE SIGNED (Month, Day, Year): ▶ 8-16-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR VELMA RANJITHAN MEMORIAL MED BLDG CUMB MD
31. DATE FILED (Month, Day, Year): AUG 17 1989
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

89 24736

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert Hoffman			2. DATE OF DEATH (Month, Day, Year): August 24, 1989	3. TIME OF DEATH: 8:50 P. M
4. SOCIAL SECURITY NUMBER: 209-03-9953	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 23, 1905	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 149 Polk St.		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Un known; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Labor	16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): Henry Hoffman	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Grace (Rile) Hoffman	
19a. INFORMANT'S NAME (Type/Print): Harvey Hoffman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O.Box 221 Berlin, PA 15530	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Restlawn Memorial Gardens	20c. LOCATION — City or Town, State: Cumberland, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ S. Mark Suggs	22. NAME AND ADDRESS OF FACILITY: George-Upchurch Funeral Home 202 Greene St., Cumb., MD 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Cirrhosis liver — 10 months

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: W. Guy Fiscus	29c. LICENSE NUMBER: D12779	29d. DATE SIGNED (Month, Day, Year): ▶ 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. W. Guy Fiscus Memorial Hospital & Medical Building Cumberland, Md. 21502

31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24737 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician. Page 4 should be retained by the funeral director. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in obtaining the burial-transit permit.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HERMAN JACOB HUTZELL			2. DATE OF DEATH (Month, Day, Year): August 21, 1989	3. TIME OF DEATH: 9:30 a.m.
4. SOCIAL SECURITY NUMBER: 705-07-9392	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11/30/1899	8. BIRTHPLACE (State or Foreign Country): PA
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: PA	10b. COUNTY: Bedford	10c. CITY, TOWN OR LOCATION: Hyndman	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: General Delivery		10f. ZIP CODE: 15545	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Trackman	16b. KIND OF BUSINESS/INDUSTRY: Railroad	
17. FATHER'S NAME (First, Middle, Last): Perry Hutzell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Lazure	
19a. INFORMANT'S NAME (Type/Print): J. Thomas Hutzell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 112 North Richard Street, Bedford, PA 15522	
20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hyndman Cemetery	20c. LOCATION — City or Town, State: Hyndman, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Harvey H. Zeigler Funeral Home, Clarence Street, Hyndman, PA 15545	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. [illegible]

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. [illegible]

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D12979	29d. DATE SIGNED (Month, Day, Year): 8/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Fiscus, Memorial Hospital Medical Building, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year): AUG 23 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

4

89 24738

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NORMA MARIE HARRIS			2. DATE OF DEATH (Month, Day, Year): August 26, 1989	3. TIME OF DEATH: 7:55 p M
4. SOCIAL SECURITY NUMBER: 220-10-4940	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11-08-1920	8. BIRTHPLACE (State or Foreign Country): WV
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 110 Altamont Street		10f. ZIP CODE: 21502		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife		16b. KIND OF BUSINESS/INDUSTRY: own home
17. FATHER'S NAME (First, Middle, Last): William Helker		18. MOTHER'S NAME (First, Middle, Maiden Surname): Thelma Shownrock		
19a. INFORMANT'S NAME (Type/Print): Frank E. Harris		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 110 Altamont Street, Cumberland, MD 21502		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Restlawn Memorial Gardens		20c. LOCATION — City or Town, State: LaVale, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. pneumonia / Respiratory failure	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. metastatic lung cancer	~2 yrs
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Mark Sagin MD	D35481	▶ 8/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Sagin, 4th Floor West, Memorial Hospital, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Gina Davidson-Kendall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24739
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
SARAH CATHERINE KAMP			8 / 22 / 89	3:50 AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
215 26 6673	1 ☐ M 2 ☒ F	61 YRS.			Feb. 4, 1928	MD

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
SACRED HEART HOSPITAL	CUMBERLAND, MD	ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Garrett	Grantsville	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
Route 2, Box 37	21536	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)	Data Entry Operator	Tire Industry
	1		

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lloyd Kamp	Bessie Warnick

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William H. Kamp	Route 2, box 37, Grantsville, MD 21536

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Smithsburg Crematory	Smithsburg, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ A. Lynn Newman	Newman Funeral HOmes, P.A. Grantsville, MD 21536

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gastrointestinal bleeding	10 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coagulopathy	10 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Liver Failure	14 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Metastatic Squamous Cell Carcinoma	3 months

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus, Pulmonary Emboli
Sepsis

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	MD 35135	▶ 8/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DR. THOMAS CHAPPELL, BMG, 912 SETON DRIVE, CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 24 1989	[signature]

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be detached and retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 may be detached and retained for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24740

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ARGYLE FOREST LANCASTER			2. DATE OF DEATH (Month / Day / Year): 9 / 1 / 89	3. TIME OF DEATH: 4:20 AM M
4. SOCIAL SECURITY NUMBER: 220 10 2111	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 82 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 9/10/06	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): FROSTBURG VILLAGE NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: FROSTBURG		9c. COUNTY OF DEATH: ALLEGANY
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: FROSTBURG		10d. INSIDE CITY LIMITS? [X] 1 YES 2 [ ] NO
10e. STREET AND NUMBER: 121 HILL STREET		10f. ZIP CODE: 21532		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 6+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MINER		16b. KIND OF BUSINESS/INDUSTRY: COAL
17. FATHER'S NAME (First, Middle, Last): FRANK LANCASTER		18. MOTHER'S NAME (First, Middle, Maiden Surname): DELLA ROBISON		
19a. INFORMANT'S NAME (Type/Print): BETTY WEBB		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. BOX 307, AUGUSTA, WV 26704		
20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FROSTBURG MEMORIAL PARK		20c. LOCATION — City or Town, State: FROSTBURG, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Marlou M Sowers		22. NAME AND ADDRESS OF FACILITY: SOWERS FUNERAL HOME, 60 W. MAIN ST. FROSTBURG, MD 21532		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure	
DUE TO (OR AS A CONSEQUENCE OF): b.	Cardiac Obstructive Pulm Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Aortic Stenosis	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	26d. DESCRIBE HOW INJURY OCCURED

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Chang Hyun Oh MD	D24951	Sept 4, 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Chang-Hyun Oh MD 48 Tara Terrace FROSTBURG, MD.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 05 1989	Julia Davidson-Randall

3

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24741

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLAUDE W. LIGHT				2. DATE OF DEATH (Month, Day, Year): August 30, 1989	3. TIME OF DEATH: 05:43 a M
4. SOCIAL SECURITY NUMBER: 215-26-6236	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 06-14-1911	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 229 Baltimore Avenue		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): lineman engineering dept.	16b. KIND OF BUSINESS/INDUSTRY: City of Cumberland	
17. FATHER'S NAME (First, Middle, Last): Myers G. Light		18. MOTHER'S NAME (First, Middle, Maiden Surname): Jeannette M. Barrett	
19a. INFORMANT'S NAME (Type/Print): Eugene M. Light Lyle F. Light		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Cumberland, MD 21502	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rose Hill Cemetery	20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiorespiratory arrest	30-30 min.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. hypopharyngeal Carcinoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Romulo Villaneuva	29c. LICENSE NUMBER: D21877	29d. DATE SIGNED (Month, Day, Year): ▶ August 30, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr Romulo Villaneuva, 913 Seton Drive, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year): SEP 01 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24742

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be removed by the funeral director or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be used as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD Leo MORRISSEY			2. DATE OF DEATH (Month, Day, Year): AUGUST 23, 1989	3. TIME OF DEATH: 6:10 A M
4. SOCIAL SECURITY NUMBER: 215-38-9146	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 10, 19 05	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 910 Holland Street		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Lt. Col. U.S. Army	16b. KIND OF BUSINESS/INDUSTRY: Military	
17. FATHER'S NAME (First, Middle, Last): Thomas Morrissey		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mabel Imes	
19a. INFORMANT'S NAME (Type/Print): Faye Purdham		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 303 Clement Street Cumberland, Md. 21502	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Burial Park	20c. LOCATION — City or Town, State: Cumberland, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ernest A. Riley, Jr.		22. NAME AND ADDRESS OF FACILITY: Leasure-Stein, Inc. 230 Baltimore Av. Cumberland, Md. 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma of the lung. DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CAP, Congestive Heart Failure.
Chronic renal failure.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D 14865	29d. DATE SIGNED (Month, Day, Year): ▶ 8-23-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Robustiano J. Barrera Memorial Hospital Medical Building Cumberland, Md. 21502		
31. DATE FILED (Month, Day, Year): AUG 24 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24743

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): TWILA MAE MILLER
2. DATE OF DEATH (Month, Day, Year): 08/18/989
3. TIME OF DEATH: 1:15A M
4. SOCIAL SECURITY NUMBER: 218626915
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): June 20 1920
8. BIRTHPLACE (State or Foreign Country): W. Va.
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland
9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: W. Va.
10b. COUNTY: Grant
10c. CITY, TOWN OR LOCATION: Gormania
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 1 Box 196
10f. ZIP CODE: 26720
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Never Worked
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Charles Miller
18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Minnich
19a. INFORMANT'S NAME (Type/Print): Mrs. Mamie Racey
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1 Box 196 Gormania, W. Va. 26720
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Pope Cemetery
20c. LOCATION — City or Town, State: Gorman, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert M. Durst M00167
22. NAME AND ADDRESS OF FACILITY: P.O. Box 243 Durst Funeral Home - Oakland, Md. 21550

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Ca of breast with Metastasis
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Osteosarcoma of bladder
DUE TO (OR AS A CONSEQUENCE OF):
c. Diabetes Mellitus
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John Mehanna
29c. LICENSE NUMBER: D-17526
29d. DATE SIGNED (Month, Day, Year): ▶ 8-18-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): DR. JOHN MEHANNA 909-B SETON DRIVE CUMBERLAND, MD 21502
31. DATE FILED (Month, Day, Year): AUG 21 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24744 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna Maitland McKenty	2. DATE OF DEATH: MONTH 9 DAY 4 YEAR 89	3. TIME OF DEATH: 2:45 AM M	
4. SOCIAL SECURITY NUMBER: 215-20-6900	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (If yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 4-24-04
8. BIRTHPLACE (State or Foreign Country): MARYLAND			
9a. FACILITY NAME (If not institution, give street and number): LIONS MANOR NURSING HOME	9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND	9c. COUNTY OF DEATH: ALLEGANY	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: CUMBERLAND	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 823 ELMWOOD LANE	10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: HOUSEWIFE
17. FATHER'S NAME (First, Middle, Last): ALFRED NIGHTENGALE	18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY LYONS	
19a. INFORMANT'S NAME (Type/Print): MARIAN McGREEVY	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 615 PIEDMONT AVE. CUMBERLAND MARYLAND 21502	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SUNSET MEMORIAL PARK	20c. LOCATION — City or Town, State: CUMBERLAND MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dale L. Merritt	22. NAME AND ADDRESS OF FACILITY: SILCOX-MERRITT FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Aspiration Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. N.C.T Feedings.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Severe Alzheimer's Disease, T.I.A & U.T.I - frequent.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: V.A. Ranjithan . M.D.	29c. LICENSE NUMBER: D19750	29d. DATE SIGNED (Month, Day, Year): ▶ 9-4-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): VIMALA. A. RANJITHAN, LIONS MANOR N.H, SETON Dr. CUM. MD 21502

31. DATE FILED (Month, Day, Year): SEP 05 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

3

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24745 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY McGann		2. DATE OF DEATH: MONTH 8 - DAY 30 - YEAR 89	3. TIME OF DEATH: 5:25 AM
4. SOCIAL SECURITY NUMBER: 218 34 4324	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 19, 1905
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND	9c. COUNTY OF DEATH: ALLEGANY	

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Lonaconing	10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2 Church St.	10f. ZIP CODE: 21539	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc.: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4 College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): John Mc Gann	18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Hamilton		
19a. INFORMANT'S NAME (Type/Print): Calvin Thrasher	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6401 Farley Rd, Pinckney, Michigan 48169		
20a. METNOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Frostburg Mem. Park	20c. LOCATION — City or Town, State: Frostburg, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donna McKee	22. NAME AND ADDRESS OF FACILITY: Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma Colon, recurrance	1 year
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
F.R. Miles MD VP/Med. Affairs	D07004	▶ 9/1/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. AUDBERTO FLORES, 924 SETON DRIVE, CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 05 1989	Gloria Davidson-Randall

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24746

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE FRANCIS MALAMPHY			2. DATE OF DEATH (Month, Day, Year): 08/29/989	3. TIME OF DEATH: 6:00 A M
4. SOCIAL SECURITY NUMBER: 214074386	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 30, 1908	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: West Virginia	10b. COUNTY: Mineral	10c. CITY, TOWN OR LOCATION: Ridgeley	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 21 Blocker St.		10f. ZIP CODE: 26753	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist	16b. KIND OF BUSINESS/INDUSTRY: Celenease Fibers Corp.	
17. FATHER'S NAME (First, Middle, Last): John Malamphy		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna (Troll) Malamphy	
19a. INFORMANT'S NAME (Type/Print): Wallace Malamphy	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 324 N. Mildred St. Apt. 2 Ranson, WV 25438		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset MemorialPärk	20c. LOCATION — City or Town, State: Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ S. Mark Sapp	22. NAME AND ADDRESS OF FACILITY: George-Upchurch Funeral Home, P.A. 202 Greene St. Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac arrhythmia	days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary artery disease.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive pulmonary Disease
Gastro intestinal bleeding

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: 033280	29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SUNIL GUPTA MD. 69 GREENE STREET CUMBERLAND, MD 21502		
31. DATE FILED (Month, Day, Year): AUG 3 0 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24747 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edward P. Matthews				2. DATE OF DEATH: MONTH 09 DAY 02 YEAR 1989	3. TIME OF DEATH: 0330 a M
4. SOCIAL SECURITY NUMBER: 220 10 2315	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 09/09/1904	8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): Frostburg Community Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Lonaconing	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 34 Church Street		10f. ZIP CODE: 21539	10g. CITIZEN OF WHAT COUNTRY? United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Ret. Coal Miner	16b. KIND OF BUSINESS/INDUSTRY: Coal	
17. FATHER'S NAME (First, Middle, Last): Peter Matthews		18. MOTHER'S NAME (First, Middle, Maiden Surname): Violet Bothwell	
19a. INFORMANT'S NAME (Type/Print): Ruth Ann Wilson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 34 Church St., Lonaconing, Md. 21539	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Laurel Hill Cemetery	20c. LOCATION — City or Town, State: Moscow, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Respiratory Failure	
DUE TO (OR AS A CONSEQUENCE OF):	b. Bilateral Pneumonia	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. Congestive Heart Failure	
DUE TO (OR AS A CONSEQUENCE OF):	d. Renal Failure	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D24951	29d. DATE SIGNED (Month, Day, Year): ▶ Sept 2, 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Oh Chang H., M.D. 48 Tarn Terrace FRostburg, MD 21532

31. DATE FILED (Month, Day, Year): SEP 05 1989	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-1a Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24748 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. It will be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
MARTHA	ANNA	NAZELROD	August 21, 1989	1:00 pM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Yr.)	8. BIRTHPLACE (State or Foreign Country)
217-10-5262	1 ☐ M 2 ☒ F	77 YRS.			07-25-1912	WV

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Memorial Hospital	Cumberland	Allegany

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Allegany	Cumberland	☒ 1 YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
447 N. Centre Street	21502	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		housewife	own home

17. FATHER'S NAME (First, Middle Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Charles L. Simpson	Ida M. Anderson

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Walter W. Nazelrod	447 N. Centre Street, Cumberland, MD 21502

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Sunset Memorial Park	Cumberland, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ James F. Scarpelli	Scarpelli Funeral Home, Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinomatosis DUE TO (OR AS A CONSEQUENCE OF):	1 year
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cholangiocarcinoma DUE TO (OR AS A CONSEQUENCE OF):	1 year
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	NA	M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Fred W. Miltenberger M.D.	D14393	▶ 23 Aug 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print)
Dr. Fred Miltenberger, 122 South Centre Street; Cumberland, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 1989	Julia Davidson-Randall

3

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-24149

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 ... the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
George T. Steward	Aug. 22, 1989	8:45 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
218-16-3435	1 ☒ M 2 ☐ F	64 YRS.			Jul 13, 1925	MD

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
229 Baltimore Ave.	Cumberland	Allegany

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Allegany	Cumberland	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
229 Baltimore Ave.	21502	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ YES 2 ☒ NO — WW II	1 ☐ YES 2 ☒ NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
9		School Bus Diver	Board of Education

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
George W. Steward	Grace E. (DuVall)

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jack A. Steward	Rt. # 8, Box 72, Cumberland, MD 21502

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Davis Memorial Cemetery	Cumberland, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ William P. Kight	Kight Funeral Home 309-311 Decatur St., Cumberland, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Giovanni Mastrangelo Deputy Medical Examiner	D07098	▶ Aug. 24, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Giovanni Mastrangelo, MD
900 Seton Drive, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 1989	Gina Davidson-Kendall

10

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24750
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM H. NORRIS, SR.					2. DATE OF DEATH (Month, Day, Year): August 27, 1989	3. TIME OF DEATH: 10:20 A.M
4. SOCIAL SECURITY NUMBER: 215-10-1205	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9-20-1901	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany	
RESIDENCE OF DECEDENT						
10a. STATE: Md.	10b. COUNTY: Allegany		10c. CITY, TOWN OR LOCATION: Mt. Savage		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: Box 435 Calla Hill			10f. ZIP CODE: 21545		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4 / College (1-4 or 5+)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance		16b. KIND OF BUSINESS/INDUSTRY: Ballistics	
17. FATHER'S NAME (First, Middle, Last): Henry Norris					18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Martin	
19a. INFORMANT'S NAME (Type/Print): Mae J. Norris			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 435 Calla Hill, Mt. Savage, Md. 21545			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Patrick Cemetery		20c. LOCATION — City or Town, State: Mt. Savage, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John P. Horn			22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home, Frostburg, Md.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bronchogenic Carcinoma

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic lung disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D3439

29d. DATE SIGNED (Month, Day, Year): 8-30-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Robustiano Barrera, Memorial Hospital Medical Building, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year): AUG 30 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

6

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24751

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Leona A. Reagan				2. DATE OF DEATH (Month, Day, Year): Sept. 2, 1989	3. TIME OF DEATH: 1:30 A.M
4. SOCIAL SECURITY NUMBER: 820-03-1702	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 7-28-1901	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Egle Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Lonaconing		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Mt. Savage	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: Old Row St.		10f. ZIP CODE: 21545	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Oscar Wolfe		18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Bean	
19a. INFORMANT'S NAME (Type/Print): Sarah Newman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 New Row St., Mt. Savage, Md. 21545	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Patricks Cemetery	20c. LOCATION — City or Town, State: Mt. Savage, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John P. Horn		22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home, Frostburg, Md.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure	years
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Atherosclerotic Coronary artery disease.	years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Multiple Cerebro Vascular accidents → Coma

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas J. Devlin MD	29c. LICENSE NUMBER: D 21488	29d. DATE SIGNED (Month, Day, Year): ▶ 9-5-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas J. Devlin, M.D. 55 Jackson St., Lonaconing, Md. 21539		
31. DATE FILED (Month, Day, Year): SEP 05 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24752

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Verda Lillian Often
2. DATE OF DEATH (Month, Day, Year): August 22, 1989
3. TIME OF DEATH: 1102 A M
4. SOCIAL SECURITY NUMBER: 215205498
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 90 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-28-98
8. BIRTHPLACE (State or Foreign Country): Md.

9a. FACILITY NAME (If not institution, give street and number): Sacred Heart Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland, Md.
9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: Mt. Savage
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: P.O. Box 240, Main St.
10f. ZIP CODE: 21545
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cafateria Worker
16b. KIND OF BUSINESS/INDUSTRY: Ballistics

17. FATHER'S NAME (First, Middle, Last): Levi Blank
18. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Wilhelm

19a. INFORMANT'S NAME (Type/Print): Gerald Often
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 580 Burt St., Barberton, Ohio

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park
20c. LOCATION — City or Town, State: Cumberland, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John P. Horn
22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home, Frostburg, Md. 21532

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ARTERIO-SCLEROTIC-HEART-DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Deouty Med. Exam.
29c. LICENSE NUMBER: MD D0[illegible]098
29d. DATE SIGNED (Month, Day, Year): 8-22-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 900 seton drive, Cumberland, Md. 21502

31. DATE FILED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24753 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marion B. Ohara			2. DATE OF DEATH (Month, Day, Year): 8 27 89	3. TIME OF DEATH: 258 PM
4. SOCIAL SECURITY NUMBER: 214-05-6387	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 02-22-1913	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Frostburg Village Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2 Miltenberger Place		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): former employee	16b. KIND OF BUSINESS/INDUSTRY: McCroys Dept. Store	
17. FATHER'S NAME (First, Middle, Last): Harry V. Whalley		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillie Kitzmiller	
19a. INFORMANT'S NAME (Type/Print): Mr. Joseph J. Whalley		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Cumberland, MD 21502	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park	20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory srreat, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pneumonitis	Sweral
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	aspiration	days.
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Alzheimers Disease.	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Htn Congestive heart failure

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S L Sandhir M D	29c. LICENSE NUMBER: D14464	29d. DATE SIGNED (Month, Day, Year): 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
S. L. Sandhir, M.D., Frostburg Community Hospital, 48 Tarn Terrace, Frostburg, MD

31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24754
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may ... hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, ... should be accepted for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES M. PHILLIPS			2. DATE OF DEATH (Month, Day, Year): 08 20 89	3. TIME OF DEATH: 4:18 A M
4. SOCIAL SECURITY NUMBER: 705-10-5131	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 02-15-05	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND		9c. COUNTY OF DEATH: ALLEGANY
RESIDENCE OF DECEDENT				
10a. STATE: West Va.	10b. COUNTY: Mineral	10c. CITY, TOWN OR LOCATION: Ridgeley		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Route 2, Box 96-E		10f. ZIP CODE: 26753		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist		16b. KIND OF BUSINESS/INDUSTRY: Western Maryland Railroad
17. FATHER'S NAME (First, Middle, Last): Monroe Phillips		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nancy Ann Cassell		
19a. INFORMANT'S NAME (Type/Print): Geneva Elsie Phillips		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 2, Box 96-E, Ridgeley, WV 26753		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park		20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Glenda D. Upchurch		22. NAME AND ADDRESS OF FACILITY: George-Upchurch Funeral Home, P.A. 202 Greene St., Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Infarction	minutes
	DUE TO (OR AS A CONSEQUENCE OF): Cardiac Arrest	hours
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF): Ventricular Fibrillation	days
	c.	
	DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic Heart Disease	years
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

		24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO		28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: W. Guy Fiscus MD	29c. LICENSE NUMBER: D12279	29d. DATE SIGNED (Month, Day, Year): ▶ 8/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. W. GUY FISCUS/MEMORIAL HOSPITAL MEDICAL BLDG./CUMBERLAND, MD. 21502		
31. DATE (Month, Day, Year): AUG 25 1989	32. [illegible]	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24755 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death and be signed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JENNIE PRESTON				2. DATE OF DEATH (Month, Day, Year): August 25, 1989	3. TIME OF DEATH: 4:17 P M
4. SOCIAL SECURITY NUMBER: 214-05-6883	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 23, 1912	8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany
RESIDENCE OF DECEDENT					
10a. STATE: Md	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Barton, Md.			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt 1, Box 69		10f. ZIP CODE: 21521		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Thomas Stafford			18. MOTHER'S NAME (First, Middle, Maiden Surname): Jeanette Sexton		
19a. INFORMANT'S NAME (Type/Print): Betty Winner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 23 Beechwood St., Lonaconing, Md. 21539			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. View Cemetery		20c. LOCATION — City or Town, State: Moscow, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James E. McKenzie		22. NAME AND ADDRESS OF FACILITY: Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebrovascular Accident	2 wks
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Yr)
	D32779	▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Guy Fiscus Memorial Hospital Medical Building, Cumberland, MD. 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Kendall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24756
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DWIGHT BURTON PROUDFOOT			2. DATE OF DEATH (Month, Day, Year): August 31, 1989	3. TIME OF DEATH: 1:25 P. M
4. SOCIAL SECURITY NUMBER: 214-07-3889	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 11-07-1913	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital & Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 31 Mullen Street		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): counselor	16b. KIND OF BUSINESS/INDUSTRY: Forestry Camp	
17. FATHER'S NAME (First, Middle, Last): Otto D. Proudfoot		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Coleman	
19a. INFORMANT'S NAME (Type/Print): Doris L. Proudfoot		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 31 Mullen Street, Cumberland, MD 21502	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Burial Park	20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Large inferior wall MI	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CAD	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Hepatic ascites.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: H C Merrick	29c. LICENSE NUMBER: D28910	29d. DATE SIGNED (Month, Day, Year): 8/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. H. C. Merrick, Memorial Hospital Medical Building, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year): SEP 01 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Kimball

DHMH-16 Rev 1/89

1 FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24757

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROSENBERGER, DONNA JEAN		2. DATE OF DEATH (Month, Day, Year): 09/01/989	3. TIME OF DEATH: 1:00P M
4. SOCIAL SECURITY NUMBER: 219520238	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 40 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 09-11-1948
8. BIRTHPLACE (State or Foreign Country): MD			
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: ALLEGANY	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cresaptown	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 14600 Spruce Street	10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): former employee	16b. KIND OF BUSINESS/INDUSTRY: fabric store	
17. FATHER'S NAME (First, Middle, Last): Forrest W. Railey	18. MOTHER'S NAME (First, Middle, Maiden Surname): Genevieve V. Dickel		
19a. INFORMANT'S NAME (Type/Print): Carl E. Rosenberger	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14600 Spruce Street, Cresaptown, MD 21502		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Eckhart Cemetery	20c. LOCATION — City or Town, State: Eckhart, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli	22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Widespread Metastasis of
DUE TO (OR AS A CONSEQUENCE OF):
ca of breast
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c. CMV infection.
DUE TO (OR AS A CONSEQUENCE OF):
d. Post Autologous Bone Marrow Transplant.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Mehanna MD	29c. LICENSE NUMBER: D-17526	29d. DATE SIGNED (Month, Day, Year): ▶ 9-2-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. JOHN MEHANNA 909-B SETON DRIVE CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year): SEP 05 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

4

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 21,758

DIVISION OF VITAL RECORDS, P.O. BOX 1314(BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed w... after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MINNIE ETHEL SHUGARS			2. DATE OF DEATH (Month, Day, Year): 08-14-989	3. TIME OF DEATH: 11:15A M
4. SOCIAL SECURITY NUMBER: 233347443	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 98 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 13 1891
8. BIRTHPLACE (State or Foreign Country): West Virginia				
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland, Md.	9c. COUNTY OF DEATH: ALLEGANY		

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Westernport,	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 235 Clay St.	10f. ZIP CODE: 21562	10g. CITIZEN OF WHAT COUNTRY? US	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Pete Saville	18. MOTHER'S NAME (First, Middle, Maiden Surname): Viney Shank		
19a. INFORMANT'S NAME (Type/Print): Verna DeShong	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 233 Clay St., Westernport, Md. 21562		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ebenezer Cemetery	20c. LOCATION — City or Town, State: Romney, WV.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Wayne Boal	22. NAME AND ADDRESS OF FACILITY: Boal-Warnick Funeral Home Westernport, Md. 21562		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Asthmatic Bronchitis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: End stage Renal failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Wagoner MD	29c. LICENSE NUMBER: D22181	29d. DATE SIGNED (Month, Day, Year): 8-15-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. GARY WAGONER 925 BISHOP WALSH CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year): SEP 14 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24759

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

13

6

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marian Elizabeth Taylor			2. DATE OF DEATH (Month, Day, Year): 8 29 1989	3. TIME OF DEATH: 10:17 a. M
4. SOCIAL SECURITY NUMBER: 214 07 2211	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8 19 1915	8. BIRTHPLACE (State or Foreign Country): U.S.A.
9a. FACILITY NAME (If not institution, give street and number): Sacred Heart Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: LaVale	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 13 N. LaVale Street		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: Schools	
17. FATHER'S NAME (First, Middle, Last): David H. Jenkins		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Williams	
19a. INFORMANT'S NAME (Type/Print): Karen Aldom		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2262 Tanglewood Dr., Salem, Ohio 44460	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Frostburg Memorial Park	20c. LOCATION — City or Town, State: Frostburg, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John P. Durst		22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home, Frostburg, Md.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial infarction	
	DUE TO (OR AS A CONSEQUENCE OF): Coronary artery disease	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Giovanni Mastrangelo Deputy Med. Ex.	29c. LICENSE NUMBER: D07098	29d. DATE SIGNED (Month, Day, Year): ▶ August 29, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Giovanni Mastrangelo, MD, 900 Seton Drive, Cumberland, MD 21502		
31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24760 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JESSIE MARIE TURNER			2. DATE OF DEATH (Month, Day, Year): 08 30 1989	3. TIME OF DEATH: 10:19 P M
4. SOCIAL SECURITY NUMBER: 220-28-9965	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (in yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 02-02-1902	8. BIRTHPLACE (State or Foreign Country): PA
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND		9c. COUNTY OF DEATH: ALLEGANY COUNTY

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 405 Prince George Street		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife	16b. KIND OF BUSINESS/INDUSTRY: own home	
17. FATHER'S NAME (First, Middle, Last): William LaRue		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Hawn	
19a. INFORMANT'S NAME (Type/Print): Mrs. Joyce E. Stegmaier		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Cumberland, MD 21502	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park	20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Arteriosclerotic Heart Disease

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D14865	29d. DATE SIGNED (Month, Day, Year): ▶ 8-31-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Robustiano Barrera, Memorial Hosptial Medical Bldg, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year): SEP 01 1989	Julia Barbara Reckard, Registrar

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-24761

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ethel Emogene Thomas
2. DATE OF DEATH (Month, Day, Year): 9 01 89
3. TIME OF DEATH: 6:14p M
4. SOCIAL SECURITY NUMBER: 219 74 9928
5. SEX: 1 ☐ M 2 ☒ F
8. AGE (In yrs. last birthday): 60 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3/31/29
8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): Frostburg Community Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg
9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: Rawlings
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Box 179
10f. ZIP CODE: 21557
10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NONE
16b. KIND OF BUSINESS/INDUSTRY: N.A.

17. FATHER'S NAME (First, Middle, Last): EDWARD L. THOMAS
18. MOTHER'S NAME (First, Middle, Maiden Surname): OLIVE KNEPP

19a. INFORMANT'S NAME (Type/Print): OLIVE THOMAS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 210 CENTER STREET, FROSTBURG, MD 21532

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SUNSET MEMORIAL PARK
20c. LOCATION — City or Town, State: CUMBERLAND, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Marlar M Sowers
22. NAME AND ADDRESS OF FACILITY: SOWERS FUNERAL HOME 60 W. MAIN ST. FROSTBURG, MD 21532

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Aspiration pneumia — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Generalized Debility — DUE TO (OR AS A CONSEQUENCE OF):	
	c. Congenital Deformity. — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jesus H Tan
29c. LICENSE NUMBER: D21244
29d. DATE SIGNED (Month, Day, Year): 9/3/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Tan, Jesus H., M.D. FRostburg Plaza Frostburg, MD 21532

31. DATE FILED (Month, Day, Year): SEP 05 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

3

Berlin, Pa.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24762
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 ... the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, ... attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VICTORIA E. WALKER			2. DATE OF DEATH (Month, Day, Year): August 19, 1989	3. TIME OF DEATH: 5:25 P M
4. SOCIAL SECURITY NUMBER: 168-54-0167	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 19, 1920	8. BIRTHPLACE (State or Foreign Country): PA
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: PA	10b. COUNTY: SOMERSET	10c. CITY, TOWN OR LOCATION: BROTHERSVALLEY TWP.	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: R.D. #3 BERLIN, PA	10f. ZIP CODE: 15530	10g. CITIZEN OF WHAT COUNTRY?: U.S.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: HOME	
17. FATHER'S NAME (First, Middle, Last): GEORGE BARKMAN		18. MOTHER'S NAME (First, Middle, Maiden Surname): ESTELLA TOSPON	
19a. INFORMANT'S NAME (Type/Print): J.P. WALKER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R.D. #3 Box 67 BERLIN, PA 15530	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): I.O.O.F. CEMETERY	20c. LOCATION — City or Town, State: BERLIN, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald B. Deaner		22. NAME AND ADDRESS OF FACILITY: DEANER FUNERAL HOME BERLIN, PA 15530	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Recurrent ovarian CA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: H. Merrick MD	29c. LICENSE NUMBER: D28910	29d. DATE SIGNED (Month, Day, Year): ▶ 8/20/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. H. C. Merrick Memorial Hospital Medical Building, Cumberland, Md. 21502

31. DATE FILED (Month, Day, Year): AUG 25 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

10

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24763 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN WATSON				2. DATE OF DEATH (Month, Day, Year): 08 22 89	3. TIME OF DEATH: 1701 P M
4. SOCIAL SECURITY NUMBER: 474-10-8943	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 08-09-08	8. BIRTHPLACE (State or Foreign Country): Alabama
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND		9c. COUNTY OF DEATH: ALLEGANY CTY

RESIDENCE OF DECEDENT

10a. STATE: WV	10b. COUNTY: Mineral	10c. CITY, TOWN OR LOCATION: Keyser	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 2 Box 166D	10f. ZIP CODE: 26726	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steel Worker	16b. KIND OF BUSINESS/INDUSTRY: Steel	
17. FATHER'S NAME (First, Middle, Last): John William Watson		16. MOTHER'S NAME (First, Middle, Maiden Surname): Pearl M. Byrd	
19a. INFORMANT'S NAME (Type/Print): John K. Watson (Son)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2 Box 166D, Keyser, WV 26726	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Elmwood Cemetery	20c. LOCATION — City or Town, State: Birmingham, AL
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wendy D. Upchurch		22. NAME AND ADDRESS OF FACILITY: George-Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, MD 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial Infarction	1 hr.
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASHD	
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Liam Watson Deputy Med. Exam.	29c. LICENSE NUMBER: MD D07098	29d. DATE SIGNED (Month, Day, Year): ▶ 8/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Giovanni Mastrangelo, 900 Seton Drive, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year): AUG 23 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24764

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
BRUCE	WAYNE	AVERILL	8 / 27 / 89	6:30 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
216-68-7145	1 [X] M 2 [ ] F	33 YRS.			Feb. 4, 1956	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
81 Milburne Circle	Pasadena	Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Md.	Anne Arundel	Pasadena	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
81 Milburne Circle	21122	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
6		unemployed	

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ronald J. Averill, Sr.	Libby G. Harris

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ronald J. Averill, Jr.	936 W. Lombard St., Balto., Md. 21223

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Western Star Cemetery	Balto., Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
[signature]	Gary L. Kaufman Funeral Home 5695 Main Street, Elkridge, Md. 21227

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Contact gunshot wound of head	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [X] YES 2 [ ] NO
head only	

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	8-26-89	M	1 [ ] YES 2 [X] NO	subject shot self
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
	home			81 Milburne Circle, Pasadena, Md.

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	OCME	8-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Ann M. Dixon, M.D. 111 Penn Street Baltimore, Md. 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 31 '89	Julia Davidson-Randall

DHMH-18 Rev 1/89

2

Amous Boyer

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24765 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): AMONS (Amos) BOYER
2. DATE OF DEATH: MONTH 8 DAY 17 YEAR 1989
3. TIME OF DEATH: 10.00 AM
4. SOCIAL SECURITY NUMBER: YES
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6-3-1908
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): ANNAPOLIS CONVALESCENT HOME
9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS
9c. COUNTY OF DEATH: ANNARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Kent
10c. CITY, TOWN OR LOCATION: WORTON Md
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: R.F.D.
10f. ZIP CODE: 21678
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): ELEM. — College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): COOK
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): William BOYER
18. MOTHER'S NAME (First, Middle, Maiden Surname): EMMA
19a. INFORMANT'S NAME (Type/Print): Miss Ethel Boyer
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R.F.D. WORTON, MD 21678
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FOUNTAIN CEM 8-22-1989
20c. LOCATION — City or Town, State: WORTON, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kenneth Wells
22. NAME AND ADDRESS OF FACILITY: 207 Calvert St. CHESTERTOWN MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Severe Vascular Disease	Several months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: R.I. Hochman M.D.
29c. LICENSE NUMBER: D5192
29d. DATE SIGNED (Month, Day, Year): 8/17/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard I. Hochman, MD - 16 Murray Ave, Annapolis, Md 21401
31. DATE FILED (Month, Day, Year): AUG 25 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

3

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24766 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thelma R. Brady
2. DATE OF DEATH: MONTH 8 DAY 21 YEAR 89
3. TIME OF DEATH: 2:50 P M
4. SOCIAL SECURITY NUMBER: 579-36-0468
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 61 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 06-03-28
8. BIRTHPLACE (State or Foreign Country): Owings, MD
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Gen. Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Lothian
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 610 Bayard Road
10f. ZIP CODE: 20711
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife
16b. KIND OF BUSINESS/INDUSTRY: Household
17. FATHER'S NAME (First, Middle, Last): Oscar Norfolk
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula Catterton
19a. INFORMANT'S NAME (Type/Print): June Horkey
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 610 Bayard Road, Lothian, MD 20711
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Lukes Episcopal Chapel
20c. LOCATION — City or Town, State: Lothian, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thomas J Hardesty
22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home, 905 Galesville Rd. Galesville, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hepatic and Renal Failure — 4 weeks
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Metastatic liver carcinoma
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ira Weinstein MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 8/21/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): IRA WEINSTEIN, SUITE 101, 330 Holiday CT
31. DATE FILED (Month, Day, Year): AUG 22 1989
32. REGISTRAR'S SIGNATURE: Jane Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-24762 (9-24767)

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Humphrey Graham Bennetts
2. DATE OF DEATH (Month, Day, Year): Aug. 22, 1989
3. TIME OF DEATH: P.M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Nov. 3, 1909
8. BIRTHPLACE (State or Foreign Country): India

9a. FACILITY NAME (If not institution, give street and number): 209 Severn Avenue
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 209 Severn Avenue
10f. ZIP CODE: 21403
10g. CITIZEN OF WHAT COUNTRY?: Great Briton

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 5 +
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer
16b. KIND OF BUSINESS/INDUSTRY: Electrical

17. FATHER'S NAME (First, Middle, Last): Graham Henry Bennetts
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Caroline Singer

19a. INFORMANT'S NAME (Type/Print): Gillian L. Griffin
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 209 Severn Avenue, Annapolis, MD 21403

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan
20c. LOCATION — City or Town, State: Alexandria, VA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Hypotension & arrhythmias	6 minutes
DUE TO (OR AS A CONSEQUENCE OF): b.	Cardiomyopathy	10 months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Myocardial infarction	1 yr.
d.	ASHD.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Emphysema / COPD.
Renal insufficiency

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S. David Kramins MD
29c. LICENSE NUMBER: 23142
29d. DATE SIGNED (Month, Day, Year): ▶ 8/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S. DAVID KRAMINS, M.D. 25 SHAW ST ANNAPOLIS, MD. 21401

31. DATE FILED (Month, Day, Year): AUG 23 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

6

89 24768

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SHARON W CUDNIK
2. DATE OF DEATH (Month, Day, Year): 8 27 89
3. TIME OF DEATH: 705 P M
4. SOCIAL SECURITY NUMBER: 218-44-8110
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 43 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 04 15 46
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS MD
9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: ANNE ARUNDEL
10c. CITY, TOWN OR LOCATION: SEVERNA PK MD
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 337 SWINTON WAY
10f. ZIP CODE: 21146
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ASST. MANAGER
16b. KIND OF BUSINESS/INDUSTRY: TELEPHONE COMPANY
17. FATHER'S NAME (First, Middle, Last): RICHARD W. WARFIELD
18. MOTHER'S NAME (First, Middle, Maiden Surname): CHARLOTTE ZIELSKI
19a. INFORMANT'S NAME (Type/Print): RICHARD J. CUDNIK
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 337 SWINTON WAY, S.P. MD 21146
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. STANISLAUS
20c. LOCATION — City or Town, State: BALTIMORE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joe A. Barranco
22. NAME AND ADDRESS OF FACILITY: 495 RITCHIE Hwy. BARRANCO F.H. SEVERNA PARK MD 21146

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Breast Cancer — Approximate Interval Between Onset and Death: 3 years

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: E W Cole MD
29c. LICENSE NUMBER: D16354
29d. DATE SIGNED (Month, Day, Year): ▶ 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E COLE 51 FRANKLIN ANNAP MD 21401

31. DATE FILED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24769
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
MERTON	L	CANTER SR	08 11 89	6.45 PM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
215-36-3841	1 [X] M 2 [ ] F	79 YRS.			Dec. 4 1909	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
NORTH ARUNDEL HOSPITAL	GLEN BURNIE	A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Prince George's	Mitchellville	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
17205 Millbranch Place	20716	United States

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	1 [ ] YES 2 [X] NO Specify:	Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
10	0	Farmer	Own Business

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
George Canter	Martha Taylor

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Merton L. Canter Jr.	Same as No. 10

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
Aug. 15 1989 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	LAKEMONT	Davidsonville, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Robert E. Evans, Pres.	Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, Maryland

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. upper Gastro-intestinal bleeding	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D 23624	▶ 8 / 13 / 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DAT[illegible] SIGNATURE
AUG 25 '89 Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24770

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Lewis	M.	Conn	8-22-89	1:00AM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
052-18-1829	1 [X] M 2 [ ] F	73 YRS.			11-16-1915	Kentucky

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Anne Arundel General Hospital	Annapolis	Anne Arundel County

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Anne Arundel	Annapolis	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
306 Beach Drive	21403	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? / IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] YES 2 [ ] NO — World War II	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)	Publisher	Newspaper

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Harry Conn	Tess Friedman

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Irene Conn	306 Beach Drive-Annapolis, MD 21403

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Metro Crematory	Catonsville, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ D. A. Barranco	495 Ritchie Hwy. Barranco Funeral Home Severna Park, MD 21146

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Complications of Stannous Flouride intoxication	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	7-27-89	M	1 [ ] YES 2 [X] NO	Ingested stannous flouride

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
store	Nationwide Pharmacy, Anne Arundel County, Maryland

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	OCME	▶ 8-22-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
James Kaplan, M.D.	111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 24771

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY CLARE GRAY
2. DATE OF DEATH (Month, Day, Year): 8 18 89
3. TIME OF DEATH: 7:59 P.M.
4. SOCIAL SECURITY NUMBER: 407-56-0774
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (If yrs. last birthday): 49 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 02-04-40
8. BIRTHPLACE (State or Foreign Country): Kentucky
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Riva
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 403 Circle Road
10f. ZIP CODE: 21140
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 5 +
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Librarian
16b. KIND OF BUSINESS/INDUSTRY: National Space and Air Museum
17. FATHER'S NAME (First, Middle, Last): Clarence Cahill
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sophia Vilkosky
19a. INFORMANT'S NAME (Type/Print): Sophia V. Cahill
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 403 Circle Road, Riva, Maryland 21140
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan
20c. LOCATION — City or Town, State: Alexandria, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Laennec's Cirrhosis of Liver	years
DUE TO (OR AS A CONSEQUENCE OF): b.	Acute and Chronic hepatitis due to ethanol	years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	with Sudden death, likely due to	
d.	Cardiac arrhythmia	instant

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Malnutrition - cachexia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Peter F. Verkouw
29c. LICENSE NUMBER: D 11653
29d. DATE SIGNED (Month, Day, Year): 8/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PETER F. VERKOUW 1833 Forest Dr. Annapolis Md 21401
31. DATE FILED (Month, Day, Year): AUG 23 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

10

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24772 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HARRY FRANCIS DEVLIN			2. DATE OF DEATH (Month, Day, Year): 8 21 89	3. TIME OF DEATH: 6 P M
4. SOCIAL SECURITY NUMBER: 177-20-3258	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): MAY 8, 1902	8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): 230 WESTWOOD RD.		9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS		9c. COUNTY OF DEATH: ANNE ARUNDEL
RESIDENCE OF DECEDENT				
10a. STATE: FLA.	10b. COUNTY: CHARLOTTE	10c. CITY, TOWN OR LOCATION: PORT CHARLOTTE		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2395 HARBOR BLVD.		10f. ZIP CODE: 33952		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired): CIVILIAN CHIEF WORLD MISSION		16b. KIND OF BUSINESS/INDUSTRY: CIVIL SERVICE	
17. FATHER'S NAME (First, Middle, Last): JOHN DEVLIN			18. MOTHER'S NAME (First, Middle, Maiden Surname): SARAH KNORR	
19a. INFORMANT'S NAME (Type/Print): PETER P. DEVLIN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 230 WESTWOOD RD. ANNAPOLIS, MD. 21401		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOLY CROSS CEMETERY	20c. LOCATION — City or Town, State: YEADON, PA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert S. Taylor		22. NAME AND ADDRESS OF FACILITY: TAYLOR FUNERAL CHAPEL, ANNAPOLIS, MD.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or reepiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CANCER LUNG
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. METASTASIS TO BRAIN, LIVER
DUE TO (OR AS A CONSEQUENCE OF):
c. AGE
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Wm A Webb	D24768	▶ 8/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 23 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

18

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24773
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LUCILLE A. ELLIOTT					2. DATE OF DEATH (Month, Day, Year): AUGUST 18, 1989		3. TIME OF DEATH: 1305 P M
4. SOCIAL SECURITY NUMBER: 243-18-4302	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): MAY 04, 1921		8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Kimbrough Army Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Ft. Meade			9c. COUNTY OF DEATH: Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE: Maryland	10b. COUNTY: Prince Georges		10c. CITY, TOWN OR LOCATION: Bowie			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 2905 Tarragon Lane			10f. ZIP CODE: 20715			10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker			16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Durward Owen Travis					18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Miller		
19a. INFORMANT'S NAME (Type/Print): Josiah Elliott			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 above				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Maryland Veterans Cemetery			20c. LOCATION — City or Town, State: Crownsville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Evans, Pres			22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Terminal adenocarcinoma of lung
DUE TO (OR AS A CONSEQUENCE OF):
c. Adenocarcinoma of Colon
DUE TO (OR AS A CONSEQUENCE OF):
d. S/P Left Pneumonectomy.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus
Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Janet M. Jones MD	16958	▶ 08-28-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Janet M. Jones, MD CPT MC USA

31. DATE (Month, Day, Year) AUG 25 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 24774

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELEANOR F. ELLIOTT					2. DATE OF DEATH: MONTH 08 DAY 26 YEAR 89	3. TIME OF DEATH: 0357 PM M
4. SOCIAL SECURITY NUMBER: 218-38-5678	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 07-21-11	8. BIRTHPLACE (State or Foreign Country): PORTSMOUTH, RI
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Odenton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 507 BRUCE AVENUE		10f. ZIP CODE: 21113	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Household	
17. FATHER'S NAME (First, Middle, Last): Daniel Reagan		18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Peabody	
19a. INFORMANT'S NAME (Type/Print): John M. Elliott		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 507 BRUCE AVE. ODENTON, MD 21113	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cem.	20c. LOCATION — City or Town, State: Arlington, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: HARDESTY FUNERAL HOME 851 Annapolis Rd, Gambrills, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. cardio respiratory arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia
Renal insufficiency

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	25. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D 23624	29d. DATE SIGNED (Month, Day, Year) ▶ 8/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BASANT KHANDELWAL, M.D. 7422 B & A BLVD., GLEN BURNIE, MD 21061

31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24775

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOROTHY HARRINGTON ELIOT			2. DATE OF DEATH (Month, Day, Year): 8 27 1989	3. TIME OF DEATH: 3 P M
4. SOCIAL SECURITY NUMBER: 055-12-8059 B	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 10, 1904	8. BIRTHPLACE (State or Foreign Country): Michigan
9a. FACILITY NAME (If not institution, give street and number): Centre Chesapeake Manor Extended Care		9b. CITY, TOWN OR LOCATION OF DEATH: Arnold		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Talbot	10c. CITY, TOWN OR LOCATION: Easton	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 417 S. Washington Street		10f. ZIP CODE: 21601	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Cornelius Harrington		18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Ryan	
19a. INFORMANT'S NAME (Type/Print): Donald L. Eliot		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2017 Chesapeake Road, Annapolis, MD 21401	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan	20c. LOCATION — City or Town, State: Alexandria, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald L. Eliot		22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CONGESTIVE HEART FAILURE	MINUTES
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CARDIOMYOPATHY	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
C. Seagren	D 33757	▶ 8-28-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 108 ASHINGTON SEAGRENA PANA CHARLES SEAGREN MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 1989	Linda Watson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24776 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Martha V. Fee
2. DATE OF DEATH (Month, Day, Year): Aug. 29, 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 231-48-7102
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 90 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): Mar. 6, 1899
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): North Arundel Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Edgewater
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 23 S. River Clubhouse Road
10f. ZIP CODE: 21037
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): James Whisman
18. MOTHER'S NAME (First, Middle, Maiden Surname): Permilia Tucker
19a. INFORMANT'S NAME (Type/Print): Wilma J. Ford
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 23 S. River Clubhouse Road, Edgewater, MD 21037
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lee Memorial Cemetery
20c. LOCATION — City or Town, State: Pennington Gap, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Massive M.I.
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: age, chronic illness

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: W. A. Dabbs MD
29c. LICENSE NUMBER: D24768
29d. DATE SIGNED (Month, Day, Year): 8/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DABBS, W. A. 703 Giddings Ave, Annapolis
31. DATE FILED (Month, Day, Year): AUG 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24777

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY E FISCHER				2. DATE OF DEATH (Month, Day, Year): 08 24 89	3. TIME OF DEATH: 0230 AM M
4. SOCIAL SECURITY NUMBER: 213-26-4982	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12-29-29	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: A.A. County	10c. CITY, TOWN OR LOCATION: Severn	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1114 Reece Road		10f. ZIP CODE: 21144	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unk.	College (1-4 or 5+): Unk.	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Howard Warrington		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret C. Wilkinson	
19a. INFORMANT'S NAME (Type/Print): Mary Ensey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1114 Reece Rd., Severn MD 21144	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park	20c. LOCATION — City or Town, State: Hanover, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert Gregory Buhn		22. NAME AND ADDRESS OF FACILITY: Kirkley Funeral Home 421 Crain Hwy. S.E. Glen Burnie, Maryland 21061	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary Arrest	
DUE TO (OR AS A CONSEQUENCE OF):	b. Respiratory Failure	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. Chronic Obstructive Lung Disease	
DUE TO (OR AS A CONSEQUENCE OF):	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kevin Doyle MD	29c. LICENSE NUMBER: D31122	29d. DATE SIGNED (Month, Day, Year): ▶ 8/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KEVIN J. DOYLE, M.D. 615 HAMMONDS LANE BALTIMORE, MARYLAND 21225

31. DATE FILED (Month, Day, Year): AUG 28 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randolph

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24778
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert Daniel Ferguson
2. DATE OF DEATH (Month, Day, Year): 08/23/89
3. TIME OF DEATH: 11:05 AM
4. SOCIAL SECURITY NUMBER: 713-03-0415
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 88 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 08/18/01
8. BIRTHPLACE (State or Foreign Country): Massachusettes
9a. FACILITY NAME (If not institution, give street and number): 24 Truckhouse Road
9b. CITY, TOWN OR LOCATION OF DEATH: Severna Park
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT
10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Severna Park
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 716 Mammouth Avenue
10f. ZIP CODE: 21146
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12+ — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Counting Clerk
16b. KIND OF BUSINESS/INDUSTRY: Railroad Industry
17. FATHER'S NAME (First, Middle, Last): John Ferguson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Hannah Mason
19a. INFORMANT'S NAME (Type/Print): Mr. Robert N. Ferguson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 716 Mammouth Avenue Severna Park MD 21146
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Peter & Paul Cem
20c. LOCATION — City or Town, State: Springfield, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James E. Barranco
22. NAME AND ADDRESS OF FACILITY: 495 Ritchie Hwy. Barranco Funeral Home Severna Park MD 21146

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory Arrest	Unknown
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Squamous Cell Cancer of Urethra	2 yr.
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John N. Kullman MD
29c. LICENSE NUMBER: D30716
29d. DATE SIGNED (Month, Day, Year): 8-24-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1833 Forest Dr. Annapolis, Md 21401
31. DATE FILED (Month, Day, Year): AUG 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

25

89 24779

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Kathryn Clara Hawkins			2. DATE OF DEATH (Month, Day, Year): Aug. 28, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 220-14-3990	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 14, 1914	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): 425 Silver Run Road		9b. CITY, TOWN OR LOCATION OF DEATH: Edgewater		9c. COUNTY OF DEATH: Anne Arundel
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Edgewater		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 425 Silver Run Road		10f. ZIP CODE: 21037		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): John A. Waddell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Annas L. Crigger		
19a. INFORMANT'S NAME (Type/Print): Ronald W. Hawkins		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1601 Ruxton Road, Edgewater, MD 21037		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cemetery		20c. LOCATION — City or Town, State: Annapolis, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeffry L. Taylor		22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the daeth. Do not enter the moda of dying, such aa cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on aech line.

		Approximate Interval Between Onset and Daeth
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cancer of the lung	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significent conditiona contributing to death but not reaulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Robert M Greenfield MD		▶

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert M. Greenfield, M.D. 139 Old Solomons Isl Rd Annapolis Md 21401

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
8/29/89	AUG 29 1989 Julia Davidson-Randall

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24,780

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)		3. TIME OF DEATH
GARDINER A. HALL JR			8	25 89	12.05 A M
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
218-28-6712	1 [X] M 2 [ ] F	55 YRS.			May 4, 1934	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Anne Arundel Medical Center	Annapolis	Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Anne Arundel	Annapolis	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
227 South Cherry Grove Avenue	21401	U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	4	Engineer	N.A.S.A.

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Gardiner A. Hall	Dorothy Westphal

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Co)
Betty C. Hall	227 South Cherry Grove Ave., Annapolis, MD 21401

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
	Hillcrest Cemetery	Annapolis, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Jeffrey S. Tayla	Taylor Funeral Chapel 21401 147 Gloucester St., Annapolis, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ca of Lung c Metastasis -	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Rodney L Brimhall M.D.	D01846.	▶ 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Rodney L. Brimhall, M.D., 1833-A Forest Drive, Annapolis, MD

31. DATE FILED (Month, Day, Year)	LOCAL REGISTRAR'S SIGNATURE
AUG 29 1989	Gina Davidson-Randall

DHMH-16 Rev 1/89

12

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24781 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUTH JACKSON		2. DATE OF DEATH (Month, Day, Year): 8-30-89	3. TIME OF DEATH: 12 45 a M
4. SOCIAL SECURITY NUMBER: 888-25-5674	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-31-04
8. BIRTHPLACE (State or Foreign Country): Washington, DC			

9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER	9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS	9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: ANNAPOLIS	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 825 HOLLY DRIVE E.	10f. ZIP CODE: 21401	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Medicine	16b. KIND OF BUSINESS/INDUSTRY: U.S. Government	
17. FATHER'S NAME (First, Middle, Last): HERBERT JACKSON	18. MOTHER'S NAME (First, Middle, Maiden Surname): NORA PYLE		
19a. INFORMANT'S NAME (Type/Print): Patricia M. Russell	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 825 Holly Drive E. Annapolis, MD 21401		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glenwood Cemetery	20c. LOCATION — City or Town, State: Washington, D.C.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Paul J Arnold Jr.	22. NAME AND ADDRESS OF FACILITY: HARDESTY FUNERAL HOME P.A. 12 RIDGELY AVE. ANNAPOLIS, MD 21401		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	ASPIRATION PNEUMONIA	24 HRS.
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	CEREBROVASCULAR ACCIDENT	6 MONTHS
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: INSULIN DEPENDENT DIABETES MELLITUS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Scott Eden, MD	29c. LICENSE NUMBER: D30701	29d. DATE SIGNED (Month, Day, Year): ▶ 8/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT SCOTT EDEN, M.D. 703 GIDDINGS AVE., ANNAPOLIS, MD 21401		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24782 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(5)

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Fannie Elizabeth Johnson				2. DATE OF DEATH (Month, Day, Year): 08 20 89	3. TIME OF DEATH: 1:25 P M
4. SOCIAL SECURITY NUMBER: 224-24-1915	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Dec. 8, 1922	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Crofton Convalescent Center			9b. CITY, TOWN OR LOCATION OF DEATH: Crofton		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Crofton	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1828 Treeview Court		10f. ZIP CODE: 21114	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — Americen Indien, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Zachary Napier		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Churchill	
19a. INFORMANT'S NAME (Type/Print): Thalia Denise Maddox		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1705 Havre De Grace Drive Edgewater, MD 21037	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory	20c. LOCATION — City or Town, State: Alexandria, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Evans Pre.		22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Arrest.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pulmonary Congestion.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Possible acute Cerebrovascular accident	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Recurrent Urinary tract Infection.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Probable lung Carcinoma.
Past History of Left Cerebrovascular accident

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Rakesh Arora. MD	29c. LICENSE NUMBER: D20108	29d. DATE SIGNED (Month, Day, Year): ▶ 8/20/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAKESH ARORA, 14300 GALLANT FOX LN BOWIE MD 20715		
31. (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24783 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY Louise KILKEARY				2. DATE OF DEATH (Month, Day, Year): 8 / 18 / 89	3. TIME OF DEATH: 12 30 p M
4. SOCIAL SECURITY NUMBER: 202-26-8566	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan. 30, 1907	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center			9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Annapolis	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 509 Powell Drive		10f. ZIP CODE: 21401	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5 +	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Librarian	16b. KIND OF BUSINESS/INDUSTRY: Private School
17. FATHER'S NAME (First, Middle, Last): John T. Johnson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mae Bracken	
19a. INFORMANT'S NAME (Type/Print): J. Philip Kilkeary		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 509 Powell Drive, Annapolis, MD 21401	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Calvary Cemetery	20c. LOCATION — City or Town, State: Pittsburgh, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald L. Taylor		22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401 147 Gloucester St., Annapolis, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. metastatic breast cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. dehydration.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO N/A

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO N/A	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY: N/A M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO N/A
	28d. DESCRIBE HOW INJURY OCCURED: N/A		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A.

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas M Walsh M.D	29c. LICENSE NUMBER: D23867	29d. DATE SIGNED (Month, Day, Year): ▶ 8/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THOMAS WALSH MD 269 Peninsula Farm Rd ARNOLD, Md 21012		
31. DATE FILED (Month, Day, Year): AUG 23 1989	32. REGISTRAR'S SIGNATURE: Julia Addison-Kinsale	

OHMH-16 Rev 1/89

3

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24784

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph Fletcher Lee		2. DATE OF DEATH (Month, Day, Year): Aug. 29, 1989	3. TIME OF DEATH: P. M
4. SOCIAL SECURITY NUMBER: 216-03-3585	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 9, 1906
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): 1673 Cliff Drive	9b. CITY, TOWN OR LOCATION OF DEATH: Mayo	9c. COUNTY OF DEATH: Anne Arundel	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Mayo	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1673 Cliff Drive	10f. ZIP CODE: 21106	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES [X]	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. OCCEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Boat Builder	16b. KIND OF BUSINESS/INDUSTRY: Marine Construction	
17. FATHER'S NAME (First, Middle, Last): Joseph Purdy Lee	18. MOTHER'S NAME (First, Middle, Maiden Surname): Sadie M. Bullen		
19a. INFORMANT'S NAME (Type/Print): Gordon Lee	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1673 Cliff Drive, Mayo, Maryland 21106		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakemont Cemetery	20c. LOCATION — City or Town, State: Davidsonville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert L. Taylor	22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Alzheimers - Advanced Dementia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: R Brimhall MD	29c. LICENSE NUMBER: D01846 MD	29d. DATE SIGNED (Month, Day, Year): ▶ 8/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Rodney L. Brimhall, M.D., 1833-A Forest Drive, Annapolis, MD

31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-18 Rev 1/89

10

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24785 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LENA ALICE MURVIN		2. DATE OF DEATH (Month, Day, Year): AUGUST 21, 1989	3. TIME OF DEATH: 1 37 P M
4. SOCIAL SECURITY NUMBER: 579-24-1196	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): MAY 17, 1912
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): ANNAPOLIS NURSING HOME	9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS	9c. COUNTY OF DEATH: ANNE ARUNDEL	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Edgewater	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1607 Arundel Road	10f. ZIP CODE: 21037	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Food Manager	16b. KIND OF BUSINESS/INDUSTRY: Drug Store	
17. FATHER'S NAME (First, Middle, Last): Clay Pierce	18. MOTHER'S NAME (First, Middle, Maiden Surname): Kathy Gray		
19a. INFORMANT'S NAME (Type/Print): Thomas E. Murvin	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1607 Arundel Rd., Edgewater, MD 21037		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery	20c. LOCATION — City or Town, State: Brentwood, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeffrey S. Taylor	22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. NUTRITIONAL INSUFFICIENCY	1 YEAR
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. SHORT BOWEL SYNDROME	"
DUE TO (OR AS A CONSEQUENCE OF):		
	c. SMALL AND LARGE BOWEL INFARCTION	"
DUE TO (OR AS A CONSEQUENCE OF):		
	d. ARTERIOSCLEROSIS	—

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC DEPRESSION

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles W. Kinzer	29c. LICENSE NUMBER: D05928	29d. DATE SIGNED (Month, Day, Year): ▶ AUG 21, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHARLES W. KINZER MD, 1833 FOREST DR, ANNAPOLIS, MD		
31. DATE FILED (Month, Day, Year): AUG 23 1989	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall	

DHMH-16 Rev 1/89

6

89 24786

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, ___ should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph W. McAbee			2. DATE OF DEATH (Month, Day, Year): August 21 1989	3. TIME OF DEATH: 2337 hrs M
4. SOCIAL SECURITY NUMBER: 212-40-2581	5. SEX: 1 ☐ M 2 ☐ F (X)	6. AGE (In yrs. last birthday): 46 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan 28,43	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Kimbrough Army Community Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Fort Meade, Maryland		9c. COUNTY OF DEATH: Anne Arundel
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Edgewater		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 (X) NO
10e. STREET AND NUMBER: 419 Cedar Grove Road		10f. ZIP CODE: 21037		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 (X) Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 (X) YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: Active Duty	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 (X) NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): -------		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Soldier		16b. KIND OF BUSINESS/INDUSTRY: U.S. Army
17. FATHER'S NAME (First, Middle, Last): Leon C. McAbee			18. MOTHER'S NAME (First, Middle, Maiden Surname): Ercelle E. Sullivan	
19a. INFORMANT'S NAME (Type/Print): Sandra K. McAbee		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 419 Cedar Grove Rd. Edgewater, MD. 21037		
20a. METHOD OF DISPOSITION: (X) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crownsville Vet. Cemetery		20c. LOCATION — City or Town, State: Crownsville, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas S. Chambers # 670		22. NAME AND ADDRESS OF FACILITY: W.W. Chambers Co. Inc. 5801 Cleveland Ave. Riverdale, MD. 20737		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Myocardial Infarct	3 hr.
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Cardiovascular Arterial Disease	10 yr.
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Hypertension	10 yr.
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 (X) NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 (X) ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 (X) Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 (X) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. Rivarola MD RIVAROLA

29c. LICENSE NUMBER: M-22388

29d. DATE SIGNED (Month, Day, Year): ▶ 21 August 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RIVAROLA, A. J. ALESANDRO RIVAROLA Kimbrough Army Community Hospital

31. DATE FILED (Month, Day, Year): SEP 12 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24787

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARGAKET S. McPHERSON

2. DATE OF DEATH (Month, Day, Year): 08 20 89

3. TIME OF DEATH: 3:15 AM

4. SOCIAL SECURITY NUMBER: 264-80-1901

5. SEX: 1 ☐ M 2 ☑ F

6. AGE (In yrs. last birthday): 95 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 1-14-94

8. BIRTHPLACE (State or Foreign Country): Illinois

9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER

9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS, MD

9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Anne Arundel

10c. CITY, TOWN OR LOCATION: Arnold

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 1280 Masters Drive

10f. ZIP CODE: 21012

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

16b. KIND OF BUSINESS/INDUSTRY: Home

17. FATHER'S NAME (First, Middle, Last): Charles Banks Shedd

18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Cossitt

19a. INFORMANT'S NAME (Type/Print): Duncan McPherson

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1280 Masters Drive, Arnold, MD 21012

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan

20c. LOCATION — City or Town, State: Alexandria, VA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeffrey L. Taylor

22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401
147 Gloucester St., Annapolis, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Heart Stopped	immediate
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Severe deterioration 2° osteoporosis & Fx	months
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD

29c. LICENSE NUMBER: D25812

29d. DATE SIGNED (Month, Day, Year): ▶ 8/20/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 139 old solomon ltc - annap md 21401

31. DATE FILED (Month, Day, Year): AUG 23 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24788

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NORA E MARTIN			2. DATE OF DEATH (Month, Day, Year): 08 24 89	3. TIME OF DEATH: 0910 AM M
4. SOCIAL SECURITY NUMBER: 221-14-4344	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3-22-12	8. BIRTHPLACE (State or Foreign Country): Del
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Glen Burnie	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 111 Elm Dr		10f. ZIP CODE: 21060	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): William Joseph Peyton		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Ann Wasturm	
19a. INFORMANT'S NAME (Type/Print): William J. Martin, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 501 Carlisle Lane Milford, DI 19963	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Odd Fellows Cemetery	20c. LOCATION — City or Town, State: Milford, DI
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert Barranco		22. NAME AND ADDRESS OF FACILITY: ROBERT S. BARRANCO SEVERNA PARK, MD. 21146	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ee cerdiec or reepiratory srreat, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final diseese or condition resulting in death) →
a. Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Severe Pulmonary emphysema
DUE TO (OR AS A CONSEQUENCE OF):
c. Bronchitis
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Abnormal glucose tolerance

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Presbitero MD	29c. LICENSE NUMBER: D16208	29d. DATE SIGNED (Month, Day, Year): 8/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSE M. PRESBITERO, M.D. 7845 OAKWOOD ROAD, #107 GLEN BURNIE, MARYLAND 21061

31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24789

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT H MOORE			2. DATE OF DEATH (Month, Day, Year): 08 23 89	3. TIME OF DEATH: 0903 AM M
4. SOCIAL SECURITY NUMBER: 236-03-0284	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 03 23 14	8. BIRTHPLACE (State or Foreign Country): W.VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: GLEN BURNIE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 310 CHAIN O'HILLS ROAD		10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): —	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AUTO MECHANIC	16b. KIND OF BUSINESS/INDUSTRY: LOCAL GOVERNMENT	
17. FATHER'S NAME (First, Middle, Last): ORIE MOORE		18. MOTHER'S NAME (First, Middle, Maiden Surname): NETIA MOORE	
19a. INFORMANT'S NAME (Type/Print): JAMES E. MOORE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 321 YALE AVENUE BALTIMORE, MD. 21229-4144	
20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LOUDON PARK	20c. LOCATION — City or Town, State: BALTIMORE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary L. Kaufmann		22. NAME AND ADDRESS OF FACILITY: RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. adult respiratory distress Syndrome
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. acute myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
c. Disseminated intravascular coagulation
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO N/A	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: 21870	29d. DATE SIGNED (Month, Day, Year) ▶ 8-23-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHARLES WU M.D. 7845 OAKWOOD ROAD, SUITE 204 GLENBURNIE, MARYLAND 21061		
31. DATE FILED (Month, Day, Year): AUG 25 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24790 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helene Przybilla				2. DATE OF DEATH (Month, Day, Year): Aug. 29, 1989	3. TIME OF DEATH: P M
4. SOCIAL SECURITY NUMBER: 577-10-1378 D	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan.10,1897	8. BIRTHPLACE (State or Foreign Country): Germany
9a. FACILITY NAME (If not institution, give street and number): Annapolis Convalescent Center			9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Edgewater	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 420 Silver Run Road		10f. ZIP CODE: 21037	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): FRANZ Hauser		18. MOTHER'S NAME (First, Middle, Maiden Surname): FLORENTINE OVZOL	
19a. INFORMANT'S NAME (Type/Print): Marie Santmyer		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 420 Silver Run Road, Edgewater, MD	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakemont Cemetery	20c. LOCATION — City or Town, State: Davidsonville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ewald A. Taylor		22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401 147 Gloucester St.,Annapolis,MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pneumonia	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Arteriosclerosis Disease	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Renal Failure

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jon B. Lowe MD	29c. LICENSE NUMBER: D19579	29d. DATE SIGNED (Month, Day, Year): 30 Aug 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jon B. Lowe, M.D., 77 West Street, Annapolis, MD 21401

31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24791

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph K. Phipps			2. DATE OF DEATH (Month, Day, Year): 8-30-89	3. TIME OF DEATH: 3:36AM M
4. SOCIAL SECURITY NUMBER: 213-96-8969	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 23 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 02-07-66	8. BIRTHPLACE (State or Foreign Country): Annapolis,MD
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis		9c. COUNTY OF DEATH: Anne Arundel County

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Friendship	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 6839 Wilson Road		10f. ZIP CODE: 20758	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction	16b. KIND OF BUSINESS/INDUSTRY: Heavy Equipment	
17. FATHER'S NAME (First, Middle, Last): Spencer A. Phipps		18. MOTHER'S NAME (First, Middle, Maiden Surname): Iris Collinson	
19a. INFORMANT'S NAME (Type/Print): BEVERLY J. W. PHIPPS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6839 Wilson Road, Friendship, MD 20758	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. James Episcopal Cem.	20c. LOCATION — City or Town, State: Tracy's Landing,MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul J. Arnold		22. NAME AND ADDRESS OF FACILITY: HARDESTY FUNERAL HOME 905 Galesville, Rd., Galesville,MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac tamponade

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Acute dissection of aorta

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-30-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin,M.D. 111 Penn Street, Baltimore,MD 21201 VC		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

DHMH-16 Rev 1/89

89 24792

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MAY ROSE ROBERTS		2. DATE OF DEATH (Month, Day, Year): 08-26-89	3. TIME OF DEATH: 11:15 PM
4. SOCIAL SECURITY NUMBER: 578-60-6688	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 06-04-06
8. BIRTHPLACE (State or Foreign Country): MARYLAND			

9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MED. CENTER	9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS	9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: MAYO	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 408 LAKEVIEW AVENUE		10f. ZIP CODE: 21106	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BUREAU OF ENGARVING	16b. KIND OF BUSINESS/INDUSTRY: U.S. GOVERNMENT	
17. FATHER'S NAME (First, Middle, Last): JOHN FOWLER		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY GARVEY	
19a. INFORMANT'S NAME (Type/Print): LENNY ROBERTS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 408 LAKEVIEW AVENUE, MAYO, MD 21106	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LAKEMONT CEMETERY	20c. LOCATION — City or Town, State: DAVIDSONVILLE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Basil J Arnold	22. NAME AND ADDRESS OF FACILITY: HARDESTY FUNERAL HOME 12 Ridgely Ave. Annapolis, MD 21401		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Staphylococcal Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Staphylococcal Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Alzheimer's Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Trying to Obtain

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jay B Lowe MD	29c. LICENSE NUMBER: D18529	29d. DATE SIGNED (Month, Day, Year): ▶ 28 Aug 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 77 West St. Annapolis, Md 21401		
31. DATE FILED (Month, Day, Year): AUG 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Rindella	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 24793

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THOMAS J. SWANN SR.			2. DATE OF DEATH (Month / Day / Year): 08 / 25 / 89	3. TIME OF DEATH: 7:40 PM
4. SOCIAL SECURITY NUMBER: 237-44-6864	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11-19-33	8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA
9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS		9c. COUNTY OF DEATH: ANNE ARUNDEL
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: CROFTON		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1789 SHAFTSBURY AVE.		10f. ZIP CODE: 21114		10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 3		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RET. US GOV.		16b. KIND OF BUSINESS/INDUSTRY: NSA
17. FATHER'S NAME (First, Middle, Last): HAROLD SWANN		18. MOTHER'S NAME (First, Middle, Maiden Surname): OMEGA HAYES		
19a. INFORMANT'S NAME (Type/Print): BARBARA K. SWANN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1789 SHAFTSBURY AVE. CROFTON, MD. 21114		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METRO CREMATORY		20c. LOCATION — City or Town, State: BALT. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Harold E. Hardesty		22. NAME AND ADDRESS OF FACILITY: HARDESTY FUNERAL HOME ANNAPOLIS MD.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Stroke (Massive Brainstem Infarct)	4 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO N/A

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James M. Chamberlain MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 8/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James M. Chamberlain, MD 700 Ritchie Hwy Severna Park MD 21146		
31. DATE FILED (Month, Day, Year): AUG 28 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Registrar	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24794
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lyle RADINE SPEAKER				2. DATE OF DEATH (Month, Day, Year): 8-22-89	3. TIME OF DEATH: 2:13AM M
4. SOCIAL SECURITY NUMBER: 308-44-7360	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 44 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10/02/1944	6. BIRTHPLACE (State or Foreign Country): Indiana
9a. FACILITY NAME (If not institution, give street and number): North Arundel Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie		9c. COUNTY OF DEATH: Anne Arundel Co.	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Arnold	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO
10e. STREET AND NUMBER: 206 Mill Church Road		10f. ZIP CODE: 21012	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES: 1962-1966	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager	16b. KIND OF BUSINESS/INDUSTRY: C.& P. Telephone Co.	
17. FATHER'S NAME (First, Middle, Last): Charles R. Speaker		18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy P. Robinette	
19a. INFORMANT'S NAME (Type/Print): Joan Speaker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 206 Mill Church Rd.,Arnold,Md. 21012	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart Cemetery	20c. LOCATION — City or Town, State: La Plata, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ D. C. Echold Jr.		22. NAME AND ADDRESS OF FACILITY: Arehart Funeral Home,Inc. P.O. Box 567,La Plata,Md. 20646	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pulmonary embolus	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Left leg deep vein thrombosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Fracture of left hip	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Arteriosclerotic cardiovascular disease

	24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: XX 1 Patient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☐ Natural XX 2 Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-17-89	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 XX YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURRED: JUMPED OUT OF BUCKET OF CRANE
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Work site			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): West Benfield Rd.,Millersville, Anne Arundel County, Maryland

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year) ▶ 8-22-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,M.D. 111 Penn Street,Baltimore,Maryland 21201 VC		
31. DATE FILED (Month, Day, Year): AUG 24 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24795
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Betty Jean Sell
2. DATE OF DEATH (Month, Day, Year): 08-22-89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 214-66-1668
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 33 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 09-20-55
8. BIRTHPLACE (State or Foreign Country): Annapolis, MD
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel M.C.
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1141 Skyway Drive
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Finance Dept.
16b. KIND OF BUSINESS/INDUSTRY: Dept. of Agriculture
17. FATHER'S NAME (First, Middle, Last): Carl B. Sell
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth V. Washington
19a. INFORMANT'S NAME (Type/Print): Carl B.Sell
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1141 Skyway D rive, Annapolis, MD 21401
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cemetery
20c. LOCATION — City or Town, State: Annapolis, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home, 12 Ridgely Ave. Annapolis, MD 21401

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic carcinoma of breast	10 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Joel B. Klein M.D.
29c. LICENSE NUMBER: D 30684
29d. DATE SIGNED (Month, Day, Year): 8/23/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOEL B. KLEIN, M.D. 2525 RIVA RD. ANNAPOLIS, MD 21401
31. DATE FILED (Month, Day, Year): AUG 25 1989
32. REGISTRAR'S SIGNATURE:

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24796

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1/2/3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUTH GREENGOLD SCHLOSSMAN		2. DATE OF DEATH (Month, Day, Year): 08-21-89	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 219-32-3062	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 05-19-18
8. BIRTHPLACE (State or Foreign Country): MARYLAND			
9a. FACILITY NAME (If not institution, give street and number): 1432 Poplar Avenue	9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis	9c. COUNTY OF DEATH: Anne Arundel	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Annapolis	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1423 Poplar Avenue	10f. ZIP CODE: 21401	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Household	
17. FATHER'S NAME (First, Middle, Last): Abraham Greengold	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ceily Pechersky		
19a. INFORMANT'S NAME (Type/Print): Melvin B. Schlossman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1423 Poplar Avenue, Annapolis, MD 21401		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Kneseth Israel Cemetery	20c. LOCATION — City or Town, State: Annapolis, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Patrick D Arnold Jr	22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home 12 Ridgely Ave. Annapolis, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Metastatic carcinoma	8 months
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Carcinoma of Lung	> 1 year
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D23162	29d. DATE SIGNED (Month, Day, Year): ▶ 8/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. David Krimins, 25 Shaw Street, Annapolis, MD

31. DATE FILED (Month, Day, Year): AUG 22 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 21797

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES W. STONE Stone, James W.		2. DATE OF DEATH (Month / Day / Year): 8 / 18 / 89	3. TIME OF DEATH: 12 55 A M
4. SOCIAL SECURITY NUMBER: 228-03-5300	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6-16-09
8. BIRTHPLACE (State or Foreign Country): Virginia			
9a. FACILITY NAME (If not institution, give street and number): Maryland Manor Convalescent Center	9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie	9c. COUNTY OF DEATH: Anne Arundel	
RESIDENCE OF DECEDENT			
10a. STATE: Md	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Glen Burnie	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 167 8th Ave. N. W.	10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unkown; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Lumber Mill Worker	16b. KIND OF BUSINESS/INDUSTRY: Industrial	
17. FATHER'S NAME (First, Middle, Last): Emory L. Stone	18. MOTHER'S NAME (First, Middle, Maiden Surname): Courtney		
19a. INFORMANT'S NAME (Type/Print): Elmer E. Stone	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 167 8th Ave. N.W. Glen Burnie, MD 21061		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Mem. Park	20c. LOCATION — City or Town, State: Glen Burnie, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert Gregory Bohn	22. NAME AND ADDRESS OF FACILITY: Kirkley Funeral Home 421 Crain Hwy. S.E., Glen Burnie, Maryland 21061		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the daeth. Do not enter the mode of dying, such as cerdiac or respiratory srrest, shock, or heart failure. List only one ceuse on aach lina.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
- a. probable cardiac arrhythmia — minutes
- DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
- b. carcinomatosis — months
- DUE TO (OR AS A CONSEQUENCE OF):
- c. non Small Carcinoma by lung biopsy
- DUE TO (OR AS A CONSEQUENCE OF):
- d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

		24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gary E. Starbek, M.D.	29c. LICENSE NUMBER: D29767	29d. DATE SIGNED (Month, Day, Year): ▶ 8/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3708 Mountain Rd Pasadena, Md 21122		
31. DATE FILED (Month, Day, Year): AUG 21 1989	32. REGISTRAR'S SIGNATURE:	

DHMH-16 Rev 1/89

89 24798

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George B. Shields
2. DATE OF DEATH: MONTH 8 DAY 23 YEAR 89
3. TIME OF DEATH: P M
4. SOCIAL SECURITY NUMBER: 199 07 7299
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 77 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-19-11
8. BIRTHPLACE (State or Foreign Country): PENN.

9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: ANNE ARUNDEL
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 102 Pinecrest Dr
10f. ZIP CODE: 21403
10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): 5+
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STATE OF MARYLAND
16b. KIND OF BUSINESS/INDUSTRY: FISH AND WILDLIFE COMM

17. FATHER'S NAME (First, Middle, Last): FRANCIS PATRICK SHIELDS
18. MOTHER'S NAME (First, Middle, Maiden Surname): JULIA MARY SCHNEIDER

19a. INFORMANT'S NAME (Type/Print): MARY LEONASHIELDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 102 PINECREST DR. ANNAPOLIS, MD 21403

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METROPOLITAN FUNERL SERVICE
20c. LOCATION — City or Town, State: ALEX. VA.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Harold A. Taylor
22. NAME AND ADDRESS OF FACILITY: TAYLOR FUNERAL CHAPEL 147 GLOUCESTER ST. ANNAPOLIS, MD.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Heart Failure	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Renal Failure	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Victor Plavner M.D
29c. LICENSE NUMBER: D 20686
29d. DATE SIGNED (Month, Day, Year): 8/23/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Victor Plavner 1509 Ritchie Highway Arnold Md
31. DATE FILED (Month, Day, Year): AUG 25 1989
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

841

Items:23,27 per ME G-656
10-18-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24799
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Steven M. Scoggan			2. DATE OF DEATH (Month, Day, Year): 8-23-89	3. TIME OF DEATH: 7:45AM M
4. SOCIAL SECURITY NUMBER: N/A	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS 2, DAYS; IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): 06/12/89	8. BIRTHPLACE (State or Foreign Country): Orlando,FL
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis		9c. COUNTY OF DEATH: Anne Arundel Co.

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Harwood	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4651 Muddy Creek Road		10f. ZIP CODE: 20776	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A	16b. KIND OF BUSINESS/INDUSTRY: N/A	
17. FATHER'S NAME (First, Middle, Last): George Edward Tydings		18. MOTHER'S NAME (First, Middle, Maiden Surname): Kelly Lynn Scoggan	
19a. INFORMANT'S NAME (Type/Print): Kelly Lynn Scoggan	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4651 Muddy Creek Rd, Harwood, MD 20776		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakemont Cemetery	20c. LOCATION — City or Town, State: Davidsonville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Floyd. Stacy Jr.	22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home 905 Galesville, Galesville, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SUDDEN INFANT DEATH SYNDROME	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita Korell	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 8-24-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year): AUG 25 1989	32. REGISTRAR'S SIGNATURE: Julia Scoldon-Lindsell

DHMH-16 Rev 1/89

89 24800

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CARL VANCE STEWART		2. DATE OF DEATH (Month, Day, Year): 08-24-89	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 241-56-6010	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 49 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11-29-39
8. BIRTHPLACE (State or Foreign Country): Highpoint, NC			
9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER	9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS	9c. COUNTY OF DEATH: ANNE ARUNDEL	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: ARNOLD	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1670 WOODTREE COURT	10f. ZIP CODE: 21012	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 [X] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Car Salesman	16b. KIND OF BUSINESS/INDUSTRY: Auto	
17. FATHER'S NAME (First, Middle, Last): Unknown	18. MOTHER'S NAME (First, Middle, Maiden Surname): Violet Stevens		
19a. INFORMANT'S NAME (Type/Print): Julia C. Stewart	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1670 Woodtree Court, Arnold, MD 21012		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakemont Cemetery	20c. LOCATION — City or Town, State: Davidsonville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thomas A Hardesty	22. NAME AND ADDRESS OF FACILITY: HARDESTY FUNERAL HOME 12 RIDGLEY AVE. ANNAPOLIS, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Hemoptysis & Exsanguination	acute
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Carcinoma of lung, squamous cell,	1 yr
DUE TO (OR AS A CONSEQUENCE OF): c.	c chronic bronchitis	
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D23-142	29d. DATE SIGNED (Month, Day, Year): ▶ 8/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S. DAVID KRIMINS MD 25 SHAW ST ANNAA, MD 21401		
31. DATE FILED (Month, Day, Year): AUG 25 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

89 24801

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARGARET L SILVER		2. DATE OF DEATH (Month, Day, Year): 08 26 89	3. TIME OF DEATH: 711 AM M
4. SOCIAL SECURITY NUMBER: 240-16-6089	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 01-23-04
8. BIRTHPLACE (State or Foreign Country): North Carolina			
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE	9c. COUNTY OF DEATH: A.A. COUNTY	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: A.A. County	10c. CITY, TOWN OR LOCATION: Glen Burnie	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 407 Baltimore Annapolis Blvd.		10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th-Grade; College (1-4 or 5+): None	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bookeeping	16b. KIND OF BUSINESS/INDUSTRY: Sparkle Cleaners Co.	
17. FATHER'S NAME (First, Middle, Last): Joe Phipps	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Elizabeth Reeves		
19a. INFORMANT'S NAME (Type/Print): Jane Vogt	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 455 Nolheight Rd., Glen Burnie, MD 21061		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park	20c. LOCATION — City or Town, State: Glen Burnie MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robt Gregory Behm	22. NAME AND ADDRESS OF FACILITY: Kirkley Funeral Home 421 Crain Hwy. S.E. Glen Burnie, Maryland 21061		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIOPULMONARY ARREST DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ANEMIA DUE TO (OR AS A CONSEQUENCE OF):	
	c. PATIENTS PRESSURE SORES DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Shavers	29c. LICENSE NUMBER: D27838	29d. DATE SIGNED (Month, Day, Year): ▶ 8/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN SHAVERS, M.D. 518 S. CAMP MEADE ROAD LINTHICUM, MARYLAND 21090		
31. DATE FILED (Month, Day, Year): AUG 28 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24802

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HELEN DOWNES TINDALL
2. DATE OF DEATH (Month, Day, Year): 8 26 89
3. TIME OF DEATH: 2 00 AM
4. SOCIAL SECURITY NUMBER: 577 10 9168
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): SEPT. 28, 1906
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 1115 GENERALS HIGHWAY
9b. CITY, TOWN OR LOCATION OF DEATH: CROWNSVILLE
9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: ANNE ARUNDEL
10c. CITY, TOWN OR LOCATION: CROWNSVILLE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1115 GENERALS HIGHWAY
10f. ZIP CODE: 21032
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BOOKKEEPER
16b. KIND OF BUSINESS/INDUSTRY: ACCOUNTING
17. FATHER'S NAME (First, Middle, Last): JAMES M. TINDALL
18. MOTHER'S NAME (First, Middle, Maiden Surname): HELEN WILLIAMS
19a. INFORMANT'S NAME (Type/Print): MARY GOTTWALS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1115 GENERALS HWY. CROWNSVILLE, MD. 21032
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METROPOLITAN
20c. LOCATION — City or Town, State: ALEXANDRIA, VA.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeffrey S. Taylor
22. NAME AND ADDRESS OF FACILITY: TAYLOR FUNERAL CHAPEL, ANNAPOLIS, MD.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Lung Cancer	4 years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: EW Cole MD
29c. LICENSE NUMBER: 016354
29d. DATE SIGNED (Month, Day, Year): ▶ 8/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EW COLE 51 FRANKLIN ST. ANNAP. MD 21401
31. DATE FILED (Month, Day, Year): AUG 29 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 24803

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Melvin C. Watkins			2. DATE OF DEATH (Month, Day, Year): 8-23-89	3. TIME OF DEATH: 7:45AM M
4. SOCIAL SECURITY NUMBER: 212-32-2025	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 53 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 4 29 36
8. BIRTHPLACE (State or Foreign Country): MARYLAND				
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel General Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis	9c. COUNTY OF DEATH: Anne Arundel County		

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: ANNAPOLIS	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 3271 Arundel On The Bay Road	10f. ZIP CODE: 21403	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: 1959-1965	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY: A.A. COUNTY UTILITIES DEPT.	
17. FATHER'S NAME (First, Middle, Last): MURRAY C. WATKINS	18. MOTHER'S NAME (First, Middle, Maiden Surname): LYDIA HARRIS		
19a. INFORMANT'S NAME (Type/Print): BERNICE WATKINS	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1107 Primrose Court Annapolis, Md. 21403		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MARYLAND VETERAN CEMETERY	20c. LOCATION — City or Town, State: CROWNSVILLE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Larry G. Reese	22. NAME AND ADDRESS OF FACILITY: 821 West St. Annapolis, Md. 21401 WILLIAM REESE & SONS MORTUARY, P.A.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-23-89	28b. TIME OF INJURY: 6:00A M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: Driver in auto/dump truck impact
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rte. 468, ½ mi. S. of Mill Swamp Road, Anne Arundel County

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita Korell	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-24-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D.	111 Penn Street, Baltimore, MD 21201 vc	
31. DATE FILED (Month, Day, Year): AUG 28 1989	32. REGISTRAR'S SIGNATURE: Gladys Reese Andrew	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24804

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or ... physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for ... transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George A. Brown		2. DATE OF DEATH (Month, Day, Year): 8 / 13 / 89	3. TIME OF DEATH: 1:02 M
4. SOCIAL SECURITY NUMBER: 213-01-4649	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 07-25-15
8. BIRTHPLACE (State or Foreign Country): Maryland			

9a. FACILITY NAME (If not institution, give street and number): Baltimore County Gen. Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown	9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Sykesville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 6256 Oakland Mills Road	10f. ZIP CODE: 21784	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Furrier	16b. KIND OF BUSINESS/INDUSTRY: Mano Swartz Furs	
17. FATHER'S NAME (First, Middle, Last): Elias Brown	18. MOTHER'S NAME (First, Middle, Maiden Surname): Blanche Trott		
19a. INFORMANT'S NAME (Type/Print): Rose Elizabeth Brown	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6256 Oakland Mills Road Sykesville, MD 21784		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park	20c. LOCATION — City or Town, State: Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Brian Luther Haight	22. NAME AND ADDRESS OF FACILITY: HAIGHT FUNERAL HOME (P.O. BOX 195) SYKESVILLE, MD 21784 795-1400		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF):	Unknown
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] ND	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Stanley Feldser MD Deputy Medical Examiner	29c. LICENSE NUMBER: D01085	29d. DATE SIGNED (Month, Day, Year): 8/13/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STANLEY J. Feldser MD 11 E. Chase St 21202		
31. DATE FILED (Month, Day, Year): AUG 15 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24805
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LEROY BOSLEY			2. DATE OF DEATH (Month, Day, Year): 8 / 11 / 89	3. TIME OF DEATH: 10 20A M
4. SOCIAL SECURITY NUMBER: 212-38-0259	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8/26/10	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): GBMC		9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON MD		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: HAMPSTEAD, MD	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4420 MT CARMEL RD		10f. ZIP CODE: 21074	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Elementary; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): David E. Bosley		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Wilhelm	
19a. INFORMANT'S NAME (Type/Print): Mr. Ralph R. Bosley		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17800 Gunpowder Rd., Hampstead, Md. 21074	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery	20c. LOCATION — City or Town, State: Upperco, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jerry A. Eline		22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home, Hampstead, Md. 21074	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIO RESPIRATORY ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. RENAL FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. SEPSIS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jose D. Delgado M	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 8/11/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR JOSE DELGADO GBMC

31. DATE FILED (Month, Day, Year): AUG 15 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24806
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Tureatha Burge			2. DATE OF DEATH: MONTH 8 DAY 21 YEAR 89	3. TIME OF DEATH: 3:17P M
4. SOCIAL SECURITY NUMBER: 238-58-7801	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9-27-13	8. BIRTHPLACE (State or Foreign Country): N.C.
9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice		9b. CITY, TOWN OR LOCATION OF DEATH: Towson, MD		9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: N.C.	10b. COUNTY: Pitt	10c. CITY, TOWN OR LOCATION: Farmville,N.C. 27828	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 406 South George Street ,Farmville,N.C.	10f. ZIP CODE: 27828	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Negro

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Teacher	16b. KIND OF BUSINESS/INDUSTRY: Public School Teacher
17. FATHER'S NAME (First, Middle, Last): Alonza Joyner		18. MOTHER'S NAME (First, Middle, Maiden Surname): Daisy B. Barrett	
19a. INFORMANT'S NAME (Type/Print): D.D. Burge		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 406 South George Street,Farmville,N.C. 27828	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Creatlawn Cemetery,	20c. LOCATION — City or Town, State: Farmville,N.C. 27828
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W. H. Bacon		22. NAME AND ADDRESS OF FACILITY: W.H. Bacon Funeral Home 3447-14th Street,N.W. Washington,D.C. 20010	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PANcreatic CA.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: C Alexander MD	29c. LICENSE NUMBER: D27087	29d. DATE SIGNED (Month, Day, Year) ▶ 8-21-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Carla S. Alexander, M.D. - 2300 Dulaney Valley Rd. - Towson, MD 21204

31. DATE FILED (Month, Day, Year): AUG 30 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B Pages 1, 2,

5

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24807
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Birdella Brown				2. DATE OF DEATH: MONTH 08 DAY 18 YEAR 89	3. TIME OF DEATH: 11:00 a M
4. SOCIAL SECURITY NUMBER: 216-34-0164	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 05/11/11	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Greater Baltimore Medical Center			9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: ANNAPOLIS	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: PRESIDENT STREET		10f. ZIP CODE: 21403	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): ROBERT PINDELL		18. MOTHER'S NAME (First, Middle, Maiden Surname): CARRIE E. BROWN	
19a. INFORMANT'S NAME (Type/Print): HILDA WHITE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5201 Linden Heights Ave. Baltimore, Md. 21225	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ASBURY TOWN NECK CHURCH CEME.	20c. LOCATION — City or Town, State: SEVERNA PARK, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Larry A. Reese		22. NAME AND ADDRESS OF FACILITY: 821 West St, Annapolis, Md 21401 WILLIAM REESE & SONS MORTUARY, P.A.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiorespiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Uberoi	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 8/18/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kuldip Uberoi M.D. G.B.M.C.

31. DATE FILED (Month, Day, Year): AUG 21 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

ONMN-16 Rev 1/89

89-24808

1-FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO [redacted]

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Nancy	Hopkins	Bryan	8-28-89	9:45AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	If UNDER 1 YEAR: MONTHS / DAYS	If UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
225-52-1774	1 ☐ M 2 ☒ F	53 YRS.			Dec. 21, 1935	Virginia

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Room 241, Comfort Inn	Pikesville	Baltimore County

98

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	[redacted]	Baltimore	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2230 Pinewood 2107.02	21214	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced 4	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify: 0	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	4	Librian	Library

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ira Hopkins	Bertha Johns Hopkins

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bertha Johns Hopkins	P. O. Box 191, Culpeper, VA 22701

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1	Culpeper Masonic Cemetery	Culpeper, VA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ [signature]	Clore Funeral Home, Inc. P. O. Box 90 Culpeper, VA

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → E956X	a. Cutting wounds of both forearms and ankles	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. DUE TO (OR AS A CONSEQUENCE OF):	
	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
☒ YES 2 ☐ NO	☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence ☒ Other (Specify) Scene 6

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURRED
1 ☐ Natural 2 ☐ Accident ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 3 6 ☐ Could not be determined	8-28-89	9:45AM	1 ☐ YES 2 ☒ NO	Self inflicted

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
Motel 6	Room 241, Comfort Inn, Pikesville Baltimore County, Maryland

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	OCME	▶ 8-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print)	
Mario F. Golle, Jr., M.D., 111 Penn Street, Baltimore, MD 21201	VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE

DO NOT WRITE IN THIS SECTION
DHMH USE ONLY

E-73 E-956X E-91

TRANS PER COPY

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24809
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Raymond Thomas Bean				2. DATE OF DEATH: Month Aug. Day 29, Year 1989	3. TIME OF DEATH: 3:30pm M
4. SOCIAL SECURITY NUMBER: 219-20-6285	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 61 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Sept. 17, 1927	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 37 Franklin Blvd.			9b. CITY, TOWN OR LOCATION OF DEATH: Reisterstown		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT					
10a. STATE: Md.	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Reisterstown			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 37 Franklin Blvd.		10f. ZIP CODE: 21136		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plumber		16b. KIND OF BUSINESS/INDUSTRY: Plumbing	
17. FATHER'S NAME (First, Middle, Last): Raymond W. Bean				18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula Moser	
19a. INFORMANT'S NAME (Type/Print): Mary Bean			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 37 Franklin Blvd., Reisterstown, Md. 21136		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Pauls Cemetery		20c. LOCATION — City or Town, State: Upperco, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ H. J. Eckhardt		22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. metastatic pancreatic cancer	22mos.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Keith Lillemoe	29c. LICENSE NUMBER: D24521	29d. DATE SIGNED (Month, Day, Year) ▶ Aug. 31, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Keith Lillemoe Dept. of Surgery 600 N Wolfe Baltimore, Md

31. DATE FILED (Month, Day, Year): AUG 31 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24810

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margaret Eva Dunn
2. DATE OF DEATH (Month, Day, Year): Aug. 18, 1989
3. TIME OF DEATH: 4:05 PM
4. SOCIAL SECURITY NUMBER: 216-09-3381
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Mar. 20, 1913
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Cherrywood Manor Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Reisterstown
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Pikesville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 124 Sherwood Avenue
10f. ZIP CODE: 21208
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 5+): 3
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: ----
17. FATHER'S NAME (First, Middle, Last): Jacob Gottschalk
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elisabeth Kuntz
19a. INFORMANT'S NAME (Type/Print): Francis S. Dunn
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 124 Sherwood Ave., Pikesville, Md. 21208
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lake View Memorial Park
20c. LOCATION — City or Town, State: Sykesville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ H.J. Eckhardt
22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel, 11605 Reisterstown Rd., Owings Mills, Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. Senile, Multi-Infarct Dementia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cerebrovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Senescence	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Decubiti

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gary A Manko
29c. LICENSE NUMBER: D25062
29d. DATE SIGNED (Month, Day, Year): ▶ 8-21-1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gary A. Manko MD, 11 Chestnut Hill Lane, Reisterstown, MD 21136
31. DATE FILED (Month, Day, Year): AUG 22 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24811
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 of 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hollis Fritz			2. DATE OF DEATH (Month, Day, Year): 8-22-89	3. TIME OF DEATH: 4:50 AM M
4. SOCIAL SECURITY NUMBER: 214-74-0951	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11/9/1897	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Ivy Hall		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Essex	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 8 Goeller Ave.		10f. ZIP CODE: 21221	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker	16b. KIND OF BUSINESS/INDUSTRY: na
17. FATHER'S NAME (First, Middle, Last): Samuel W. Glover		18. MOTHER'S NAME (First, Middle, Maiden Surname): Harriett E. Deeds	
19a. INFORMANT'S NAME (Type/Print): Catherine Stuller		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 Goeller Ave., Baltimore, Md. 21221	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Deer Park	20c. LOCATION — City or Town, State: Smallwood, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert K. Pritts, Sr.		22. NAME AND ADDRESS OF FACILITY: 412 Washington Rd. Westminster, Md. 21157	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. POSSIBLE Acute MI c Pulm Edema.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DEMENTIA, OLD MI, DIABETES, SENILITY

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D14221	29d. DATE SIGNED (Month, Day, Year): ▶ 8.22.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): 2234 E. Blvd Baltimore 21224 (T.A. Fikaris MD)		
31. DATE FILED (Month, Day, Year): AUG 28 89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 24812

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
HAYMIRE, ANNA ANNA Mary Haymire		08/28/89	12;10 pm M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
216-28-9769-A	1 ☐ M 2 ☒ F	80 YRS.			03/11/09	MD

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
ST, LUKE . UTHERAN, 7600 CLAYS LANE	BALTIMORE, MD. 21207	BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	BALTO.	LOCHEARN	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2800 RIDGE Rd.	21207	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		HOUSEKEEPER	MASONIC HOME

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
LOUIS W. STAUBITZ	MARY ELIZABETH VEBEL

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
EDWARD HAYMIRE	2800 RIDGE Rd. LOCHEARN, MD. 21207

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)	LAKE VIEW CEMETERY	SYKESVILLE, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Brian L. Haight	HAIGHT F.H. Box 195 SYKESVILLE, MD 21784

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma) the lung	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined			1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D18324	▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Moges Gebremariam 4660 Wilkens Ave # 202. Balto 21229

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 1 89	

DHMH-16 Rev 1/89

89 24813

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES A. HALL				2. DATE OF DEATH: MONTH 8 DAY 14 YEAR 89	3. TIME OF DEATH: 0135 M
4. SOCIAL SECURITY NUMBER: 220-09-9620	5. SEX: 1 X M 2 ☐ F	8. AGE (In yrs. last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 02-25-10	6. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown		9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Carroll County	10c. CITY, TOWN OR LOCATION: Sykesville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 6525 Sunset Drive		10f. ZIP CODE: 21784	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Certified Public Accountant	16b. KIND OF BUSINESS/INDUSTRY: State of Maryland
17. FATHER'S NAME (First, Middle, Last): Samuel Hall		18. MOTHER'S NAME (First, Middle, Maiden Surname): Belva Turner	
19a. INFORMANT'S NAME (Type/Print): Elizabeth W. Hall		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6525 Sunset Drive Sykesville, MD 21784	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lake View Cemetery	20c. LOCATION — City or Town, State: Sykesville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian Luther Haight		22. NAME AND ADDRESS OF FACILITY: HAIGHT FUNERAL HOME (P.O. BOX 195) SYKESVILLE, MARYLAND 21784 795-1400	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ESOPHAGEAL VARICEAL BLEED	10 MIN
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CIRRHOSIS WITH ASCITES	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHF, RIGHT PLEURAL EFFUSION

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: C. Ravi MD	29c. LICENSE NUMBER: D37333	29d. DATE SIGNED (Month, Day, Year) ▶ 8.16.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. RAVI MD, BCGH, RANDALLSTOWN, MD.		
31. DATE FILED (Month, Day, Year): AUG 15 89	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-24814

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Emil Joseph Logomarsine			2. DATE OF DEATH (Month - Day - Year): 08 - 20 - 89	3. TIME OF DEATH: 4:45 a M
4. SOCIAL SECURITY NUMBER: 579-68-4103	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 85 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 08-12-04	8. BIRTHPLACE (State or Foreign Country): New Jersey
9a. FACILITY NAME (If not institution, give street and number): Key Circle Hospice		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimare
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 1214 Eutaw Place		10f. ZIP CODE: 21217		10g. CITIZEN OF WHAT COUNTRY?: U.S.
11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: W.W.1	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): -------		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None		16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): Louis Logomarsine		18. MOTHER'S NAME (First, Middle, Maiden Surname): Clemetina Klepping		
19a. INFORMANT'S NAME (Type/Print): Key Circle Hospice		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1214 Eutaw Place Baltimore, MD 21217		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hollywood Cemetery		20c. LOCATION — City or Town, State: Union N.J.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas S. Chambers # 670		22. NAME AND ADDRESS OF FACILITY: W.W.Chambers Co. Inc. 5801 Cleveland Ave. Riverdale, MD.20737		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIOPULMONARY ARREST

DUE TO (OR AS A CONSEQUENCE OF):
b. Chronic Obstructive Pulmonary Disease

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: N/A M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED: N/A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Surjit Julka
29c. LICENSE NUMBER: D26395
29d. DATE SIGNED (Month, Day, Year): ▶ 8-21-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SURJIT S JULKA M.D. 821 N. EUTAW ST. Baltimore MD 21201

31. DATE FILED (Month, Day, Year): SEP 12 1989
REGISTRAR'S SIGNATURE: Julia Hudson-Rapley

DHMH-16 Rev 1/89

89 24815

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PAUL A. LOGUE				2. DATE OF DEATH (Month, Day, Year): 8 16 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 214-09-2426	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11-14-1901	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): St. Joseph's Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 132 E. Green St.		10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Broker/realtor	16b. KIND OF BUSINESS/INDUSTRY: Real estate	
17. FATHER'S NAME (First, Middle, Last): Francis A. Logue		18. MOTHER'S NAME (First, Middle, Maiden Surname): Cleavie	
19a. INFORMANT'S NAME (Type/Print): Jane Myers		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 139 City View Ave., Westminster, Md. 2117	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Conewago Chapel Cemet.	20c. LOCATION — City or Town, State: McSherrystown, PA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R. Kyle Pritts		22. NAME AND ADDRESS OF FACILITY: Pritts Funeral Home & Chapel 412 WASHINGTON Rd. Westminster 21157	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HEMOPERICARDIUM & LEFT — minutes

DUE TO (OR AS A CONSEQUENCE OF): HEMOTHORAX following

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): coronary bypass surgery

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CORONARY ARTERIOSCLEROSIS

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Maurice B Furlong Jr	29c. LICENSE NUMBER: D17966	29d. DATE SIGNED (Month, Day, Year): 17 Aug 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MAURICE B FURLONG JR / ST JOSEPH HOSPITAL		
31. DATE FILED (Month, Day, Year): AUG 18 89	32. REGISTRAR'S SIGNATURE: Julia Davidson Mitchell	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24816 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LOUIS CHARLES LISTER			2. DATE OF DEATH (Month, Day, Year): 8 15 89	3. TIME OF DEATH: 2:45 A M
4. SOCIAL SECURITY NUMBER: 213-16-4466	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-18-1912	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): BALTIMORE CO. GENERAL		9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: CARROLL	10c. CITY, TOWN OR LOCATION: WESTMINSTER	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 777 OLD MANCHESTER, RD.		10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY?: U.S.A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CANNERY	16b. KIND OF BUSINESS/INDUSTRY: AGRICULTURE	
17. FATHER'S NAME (First, Middle, Last): HOWARD LISTER		18. MOTHER'S NAME (First, Middle, Maiden Surname): VERONICA PIETRZAK	
19a. INFORMANT'S NAME (Type/Print): DOLORES E. STEIN	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 777 OLD MANCHESTER Rd. WESTMINSTER MD 21157		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CARROLL CREMATORY	20c. LOCATION — City or Town, State: HAMPSTEAD, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert A. Myers	22. NAME AND ADDRESS OF FACILITY: 91 Gorsuch St MYERS FUNERAL HOME WESTMINSTER, MD 21157		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edmund P. Tkaczuk	29c. LICENSE NUMBER: D34951	29d. DATE SIGNED (Month, Day, Year) ▶ 8/15/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EDMUND P. TKACZUK Balt County General Hospital		
31. DATE FILED (Month, Day, Year): AUG 18 89	32. REGISTRAR'S SIGNATURE: Gina [illegible]-Mondello	

DHMH-18 Rev 1/89

89 24817

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY E. McGUIRE			2. DATE OF DEATH (Month, Day, Year): August 5, 1989	3. TIME OF DEATH: 11 A. M
4. SOCIAL SECURITY NUMBER: 193-12-3608	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 65 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 7, 1923	8. BIRTHPLACE (State or Foreign Country): Penna
9a. FACILITY NAME (If not institution, give street and number): 8 White Birch Court		9b. CITY, TOWN OR LOCATION OF DEATH: Reisterstown		9c. COUNTY OF DEATH: Balto.
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Balto.	10c. CITY, TOWN OR LOCATION: Reisterstown		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 8 White Birch Court		10f. ZIP CODE: 21136		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2 Yrs. College	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Patrick Kelley		18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Monahan		
19a. INFORMANT'S NAME (Type/Print): Ms. Donna M. Brickley		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 White Birch Ct. Reisterstown, Md. 21136		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Calvary Cemetery		20c. LOCATION — City or Town, State: Cherry Hill N.J.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ann B Eline		22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home Reisterstown, Md. 21136		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. brest cancer	8 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Alan Kimmel	D25743	▶ 8/7/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alan Kimmel MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
8/7/89 AUG 14 89	Josha Davidson-Rondelle

DHMH-16 Rev 1/89

89 24818

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mildred H Mercer					2. DATE OF DEATH (Month, Day, Year): 08 15 89		3. TIME OF DEATH: 2:45 pM
4. SOCIAL SECURITY NUMBER: 069-18-1717	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 07/28/12		8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Greater Baltimore Medical Center			9b. CITY, TOWN OR LOCATION OF DEATH: Towson			9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Reistertown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 407 Valley Meadow Circle A1		10f. ZIP CODE: 21136	10g. CITIZEN OF WNAT COUNTRY?: USA.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: Education
17. FATHER'S NAME (First, Middle, Last): Andrew Hasler		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bortel	
19a. INFORMANT'S NAME (Type/Print): William K, Mercer		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 407 Valley Meadow Circle, A1, Reisterstown, Md. 21136	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Williamsville Cemetery	20c. LOCATION — City or Town, State: Williamsville, New York
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R Larry Nicklinger		22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel Owings Mills, Md. 21117	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Metastatic Squamous Cell CA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Olakunle D. Ajanaku MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): 8/15/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Olakunle D. Ajanaku G.B.M.C.

31. DATE FILED (Month, Day, Year): AUG 16 '89	32. REGISTRAR'S SIGNATURE: Janet Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B Page 3 should

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24819

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLARENCE R. MITZEL
2. DATE OF DEATH: MONTH 8 DAY 28 YEAR 89
3. TIME OF DEATH: 0400 M
4. SOCIAL SECURITY NUMBER: 218051712
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): 70 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-21-1918
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Baltimore County Gen. Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: 5402 Arcadia Avenue Arcadia
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 5402 Arcadia Ave.
10f. ZIP CODE: 21155
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintance Man
16b. KIND OF BUSINESS/INDUSTRY: State of Maryland
17. FATHER'S NAME (First, Middle, Last): Ross Mitzel
18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha M. Dorn
19a. INFORMANT'S NAME (Type/Print): Carolyn James
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5402 Arcadia Ave., Arcadia, Maryland 21155
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lake View Mem. Park
20c. LOCATION — City or Town, State: Sykesville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. Larry Nightingale
22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel, 3296 Charmil Dr., Manchester, Md. 21102

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CHRONIC LYMPHOCYTIC LEUKEMIA	0 mo
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HERPES ZOSTER, DIABETES, CHF, CHOLELITHIASIS, ANKYLOSING SPONDYLITIS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: C. Rivi MD
29c. LICENSE NUMBER: D37733
29d. DATE SIGNED (Month, Day, Year): ▶ 8.28.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Baltimore Co. Gen. Hospital, Randallstown, Md.
31. DATE FILED (Month, Day, Year): AUG 29 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-t6 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24820

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): May Geraldine Renner			2. DATE OF DEATH (Month, Day, Year): 8 27 89	3. TIME OF DEATH: 12:30 P M
4. SOCIAL SECURITY NUMBER: 216-05-9864	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 26, 1909	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Baltimore County Gen. Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Owings Mills	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6 Haines Court		10f. ZIP CODE: 21117	10g. CITIZEN OF WHAT COUNTRY?: USA.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Buyer	16b. KIND OF BUSINESS/INDUSTRY: Hardware	
17. FATHER'S NAME (First, Middle, Last): George R. Kries		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida M. Scharf	
19a. INFORMANT'S NAME (Type/Print): Henry J. Renner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 Haines Court, Owings Mills, Md. 21117	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen Mem. Gardens	20c. LOCATION — City or Town, State: Finksburg, Md. 21048	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R Lacy Nightingale	22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel, Owings Mills, Md. 21117		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Bilateral Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute Respiratory Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Bladder carcinoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Recurrent Congestive Heart Failure	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edward J. Klein MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 8-27-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 8620 Liberty Rd 2 RM 4 Randallstown md 21133.		
31. DATE FILED (Month, Day, Year): AUG 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 24821

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE RUSSELL WELDEN			2. DATE OF DEATH: MONTH 08 DAY 22 YEAR 89	3. TIME OF DEATH: 5:00 AM
4. SOCIAL SECURITY NUMBER: 705 03 7556	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 07/07/14	8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Cockeysville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 14830 Falls Road		10f. ZIP CODE: 21030	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12; College (1-4 or 5+):	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanical Engineer	16b. KIND OF BUSINESS/INDUSTRY: Westinghouse	
17. FATHER'S NAME (First, Middle, Last): Walter R. Welden		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella N. Bauer	
19a. INFORMANT'S NAME (Type/Print): Mrs. B. Pauline Welden		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14830 Falls Road, Cockeysville, Md. 21030	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Black Rock Cemetery	20c. LOCATION — City or Town, State: Butler, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Steven W. Eline		22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home, 934 S. Main St. Hampstead, Maryland 21074	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPSIS	8/22
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. IMMUNOSUPPRESSION	8/16-8/22
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. METASTATIC COLON CARCINOMA	9/87
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
NOREEN RAHAT HASHMI Noreen Rahat Hashmi	17812361	8-22-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NOREEN RAHAT HASHMI G.B.M.C.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 24 '89	Julia Davidson-Randall

OHMH-16 Rev 1/89

89 24822

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH ANTHONY AQUILLA		2. DATE OF DEATH (Month, Day, Year): 08 / 24 / 89	3. TIME OF DEATH: 1800 P M
4. SOCIAL SECURITY NUMBER: 219-38-7550	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 09/09/12
8. BIRTHPLACE (State or Foreign Country): MD			
9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: ELLICOTT CITY	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 3437 TYLER DRIVE	10f. ZIP CODE: 21043	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Police Officier	16b. KIND OF BUSINESS/INDUSTRY: Baltimore City
17. FATHER'S NAME (First, Middle, Last): Anthony Joseph Aquilla		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosalia Centeneo	
19a. INFORMANT'S NAME (Type/Print): Mrs Louise Aquilla		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3437 Tyler Drive Ellicott City Md 21043	
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crestlawn Cemetery	20c. LOCATION — City or Town, State: Howard County	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry H. Witzke	22. NAME AND ADDRESS OF FACILITY: Harry H Witzke Funeral Home Inc 4112 Old Columbia Pike Ellicott City		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ASPIRATION PNEUMONIA
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. SUBDURAL HEMATOMA
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year) ▶ 08/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALEXANDER O.S.Y. M.D

31. DATE FILED (Month, Day, Year): AUG 25 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 24823

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Walter H. Borck			2. DATE OF DEATH: MONTH 8 DAY 10 YEAR 89	3. TIME OF DEATH: 11:50 PM
4. SOCIAL SECURITY NUMBER: 216-68-3378	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 31 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10/7/57	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Baltimore City		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1264 James St.		10f. ZIP CODE: 21223		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Walter H. Borck			18. MOTHER'S NAME (First, Middle, Maiden Surname): Shirley Long	
19a. INFORMANT'S NAME (Type/Print): Shirley F. Borck		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1264 James Street, Balto., Md. 21223		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery		20c. LOCATION — City or Town, State: Glen Burnie, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶		22. NAME AND ADDRESS OF FACILITY: Gary L. Kaufman Funeral Homes 5695 Main Street, Elkridge, Maryland 21227		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. HYPOVOLEMIA
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. BLOOD LOSS
DUE TO (OR AS A CONSEQUENCE OF):
c. ESOPHAGEAL VARICES
DUE TO (OR AS A CONSEQUENCE OF):
d. ALCOHOLIC LIVER DISEASE

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶
HOUSE STAFF		

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HARBOR HOSPITAL CENTER, 3001 S. HANOVER ST., BALTIMORE, MD 21230

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 16 '89	Julia Davidson-Randall

DHMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24824 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to issue the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
DORIS	CLAIRE	BAUER	AUGUST 6, 1989	9:45 pm

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
213-05-4167	1 ☐ M 2 ☒ F	75 YRS.			June 27, 1914	Balto. Md.

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
MARYLAND GENERAL HOSPITAL	BALTIMORE CITY	BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Md.	Baltimore	Reisterstown	1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
20 Nicodemus Road	21136	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
☒ 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
High School		Bookkeeper	

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
J. Harry Bauer	Evelyn George

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Jeanne B. Bradley	20 Nicodemus Road Reisterstown, Md.21136

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Lorraine Park Cemetery	Baltimore, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ James B Bradley	Eline Funeral Home Reisterstown, Md.21136

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular disease	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Retro peritoneal neoplasm	
DUE TO (OR AS A CONSEQUENCE OF):		
	c. Gangrene of the left foot	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Remote Myocardial Infarction

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
R. Diaz M.D.	N/A	▶ 8/7/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
Rodrigo Diaz, M.D.	c/o Maryland General Hospital

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 14 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24825 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SYLVESTER L. Brown					2. DATE OF DEATH: MONTH 8 DAY 23 YEAR 89	3. TIME OF DEATH: 4:30 p M
4. SOCIAL SECURITY NUMBER: 212-32-0513-A	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5-15-23	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not Institution, give street and number): ST. AGNES HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE			9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 916 NORTH STRICKER STREET		10f. ZIP CODE: 21203	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [XX] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — Amaricen Indien, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TEACHER	16b. KIND OF BUSINESS/INDUSTRY: SCHOOL FOR THE BLIND	
17. FATHER'S NAME (First, Middle, Last): CHARLES E. BROWN		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET GREEN	
19a. INFORMANT'S NAME (Type/Print): GENEVA SIMMONS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11441 DULEY STATION RD. UPPER MARLBORO, MD. 20772	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): RESURRECTION CEMETERY	20c. LOCATION — City or Town, State: CLINTON, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: B. L. Taylor		22. NAME AND ADDRESS OF FACILITY: ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASH. D.C. 20019	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute renal failure	7 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Probable Hepatorenal syndrome	7 days
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Advanced Terminal liver cirrhosis + portal HTN	14 yr
DUE TO (OR AS A CONSEQUENCE OF):		
d.	Alcoholism	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas Lee, MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 8/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): 8 29 89	32. REGISTRAR'S SIGNATURE: Sheila Davidson-Randall

DNMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24826 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lucille N. Cafardi				2. DATE OF DEATH (Month, Day, Year): 8 13 89	3. TIME OF DEATH: 0110A M
4. SOCIAL SECURITY NUMBER: 577-01-9473	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11-29-03	8. BIRTHPLACE (State or Foreign Country): Wash., DC
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Lansdowne	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 243 Third Ave.		10f. ZIP CODE: 21227	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): William Smith		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna M. Beach	
19a. INFORMANT'S NAME (Type/Print): John L. Smith		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 243 Third Avenue, Lansdowne, Md. 21227	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Congressional Cemetery	20c. LOCATION — City or Town, State: Washington, D.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Gary L. Kaufman Funeral Homes 5695 Main Street, Elkridge, Md. 21227	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. DO not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cerebro Vascular accident	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☒ NO NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M. Dimakis, House Office	29c. LICENSE NUMBER:	29d. DATE SIGNED (Month, Day, Year) ▶ 8.13.89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MAZEN DIMACHKIE, 900 Caton Ave, Baltimore, MD 21229

31. DATE FILED (Month, Day, Year): AUG 16 89	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

89 24827

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph E Coffin		2. DATE OF DEATH (Month, Day, Year): 08 23 89	3. TIME OF DEATH: 9 22 P M
4. SOCIAL SECURITY NUMBER: 212-22-5667	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 60 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 09/28/28
8. BIRTHPLACE (State or Foreign Country): MD			
9a. FACILITY NAME (If not institution, give street and number): Loch Raven VA Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore MD	9c. COUNTY OF DEATH: Baltimore City	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Annapolis	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 112 Rosemond Road	10f. ZIP CODE: 21403	10g. CITIZEN OF WHAT COUNTRY? USA	

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1946 - 1949	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner / Operator	16b. KIND OF BUSINESS/INDUSTRY: Electronics Shop	
17. FATHER'S NAME (First, Middle, Last): Charles J. Coffin, Sr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Renner		
19a. INFORMANT'S NAME (Type/Print): Mr. Jeffrey S. Coffin	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1769 Whisper Hill Dr., Reston, VA 22094		
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MD Veterans Cemetery	20c. LOCATION — City or Town, State: Crownsville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert B	22. NAME AND ADDRESS OF FACILITY: Barranco Severna Park Funeral Home		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Small Cell Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypernatremia

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) Hospital	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Henry W. Burnett MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Henry W. Burnett University Hospital Dept of Medicine 22 S Greene St Baltimore MD 21201		
31. DATE FILED (Month, Day, Year): 8/23/89	32. REGISTRAR'S SIGNATURE: Henry Burnett	

AUG 30 1989 Julia Davidson-Randall

DHMH-18 Rev 1/89

89 24828

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Baby Boy Daugherthy / FREEMAN JOSEPH DAUGHERTY III
2. DATE OF DEATH (Month, Day, Year): 8/28/89
3. TIME OF DEATH: 1'20 PM
4. SOCIAL SECURITY NUMBER: —
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 8 day YRS. IF UNDER 1 YEAR: MONTHS — DAYS 8 IF UNDER 24 HRS.: HOURS — MIN. —
7. DATE OF BIRTH (Month, Day, Year): 8/20/89
8. BIRTHPLACE (State or Foreign Country): Sinia Hospital
9a. FACILITY NAME (If not institution, give street and number): SINIA HOSPITAL BALTimor MD
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE MD.
9c. COUNTY OF DEATH: U.S.A

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: PATAPSCO FINKSBURG
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3233 MURRAJ Rd
10f. ZIP CODE: 21048
10g. CITIZEN OF WHAT COUNTRY? U.S.A
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: W
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): —
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.):
16b. KIND OF BUSINESS/INDUSTRY: —
17. FATHER'S NAME (First, Middle, Last): Freeman Daughertj
18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia JULEE LYNN MINGEE
19a. INFORMANT'S NAME (Type/Print): FREEMAN J. DAUGHERTY JR.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3233 MURRAY RD. #15 FINKSBURG MD. 21048
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): RESURRECTION CEMETERY
20c. LOCATION — City or Town, State: CLINTON MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward G. Mudd
22. NAME AND ADDRESS OF FACILITY: HUNTT FUNERAL HOME P.O. BOX 156 WALDORF, MARYLAND 20604

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypoxemia secondary To Severe lung disease
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Hyalin membrane disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Pulmonary interstitial Emphysema 2nd Primo Thorax
DUE TO (OR AS A CONSEQUENCE OF):
d. possible Superimposed infection.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: prematurity; intraventricular Bleeding

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural (Secondary To lung disease) 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year): 8/28/89
26b. TIME OF INJURY: 1'20 PM
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED: —
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): FSK
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State): BALTIMOR MD.
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Homa Miknafs MD.
29c. LICENSE NUMBER: D37630
29d. DATE SIGNED (Month, Day, Year): ▶ 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HOMA MIKNAFS Francis Scott Key Hosp.
31. DATE FILED (Month, Day, Year): SEP 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24829
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Fannie Ethel Delauder
2. DATE OF DEATH (Month, Day, Year): Aug. 20, 1989
3. TIME OF DEATH: 9:30 PM
4. SOCIAL SECURITY NUMBER: 232-20-3969
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Dec. 28, 1919
8. BIRTHPLACE (State or Foreign Country): W. Va.
8a. FACILITY NAME (If not institution, give street and number): 2246 Cedley Street
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2246 Cedley Street
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Packer
16b. KIND OF BUSINESS/INDUSTRY: Glasshouse
17. FATHER'S NAME (First, Middle, Last): Alby Cunningham
18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Cunningham
19a. INFORMANT'S NAME (Type/Print): Estella Delauder
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2230 Cedley St., Baltimore, Md. 21230
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fansler Hill Cemetery
20c. LOCATION — City or Town, State: Hendricks, W. Va.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary L. Kaufman
22. NAME AND ADDRESS OF FACILITY: Gary L. Kaufman Funeral Homes, 5695 Main Street, Elkridge, Md. 21227

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Renal Carcinoma
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diffuse Metastatic Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Jorge Valle
29c. LICENSE NUMBER: D26203
29d. DATE SIGNED (Month, Day, Year): ▶ 8/21/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jorge Valleciillo, MD 4000 Annapolis Rd Baltimore, MD 21227
31. DATE FILED (Month, Day, Year): AUG 23 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

Items:23,27 per ME G-656
10-18-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24830

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): (BABY) Lauren Marie Desombre				2. DATE OF DEATH (Month, Day, Year): 8-23-89	3. TIME OF DEATH: 11:45AM M
4. SOCIAL SECURITY NUMBER: N/A	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): YRS.	IF UNDER 1 YEAR: MONTHS 4 DAYS 13 / IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): 4-10-89	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT					
10a. STATE: MD	10b. COUNTY: Anne Arundel		10c. CITY, TOWN OR LOCATION: Glen Burnie		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 711 Delmar Road			10f. ZIP CODE: 21061		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A / College (1-4 or 5+): N/A			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A		16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): Dale W. DeSombre Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname): Susan Lembach	
19a. INFORMANT'S NAME (Type/Print): Dale W. DeSombre Sr.			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 711 Delmar Rd.,Glen Burnie MD 21061		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Mem. Park		20c. LOCATION — City or Town, State: Glen Burnie, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert Gregory Burke			22. NAME AND ADDRESS OF FACILITY: Kirkley Funeral Home,421 Crain Hwy.S.E. Glen Burnie Maryland 21061		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SUDDEN INFANT DEATH SYNDROME	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
☒ YES 2 ☐ NO	☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Margarita A. Korell, M.D.	OCME	▶ 8-24-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 28 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24831
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLARENCE EDWARD FIGGS			2. DATE OF DEATH (Month, Day, Year): Aug. 28, 1989	3. TIME OF DEATH: 8:21 am M
4. SOCIAL SECURITY NUMBER: 212-28-9818	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 59 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 12, 1930	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1607 Mosher St.		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: ---	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1607 Mosher St.		10f. ZIP CODE: 21217	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [XX] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver	16b. KIND OF BUSINESS/INDUSTRY: Trucking	
17. FATHER'S NAME (First, Middle, Last): Lewis Nelson Figgs		18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha L. Jefferson	
19a. INFORMANT'S NAME (Type/Print): Lewis Figgs		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3015 Ridgewood Ave., Balto., Md. 21215	
20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Lukes Cemetery	20c. LOCATION — City or Town, State: Reisterstown, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. Sam Nightingale		22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel ,11605 Reisterstown Rd., Owings Mills, Md.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Severe dilated cardiomyopathy	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): ASCVD	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	26a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: R. Moghbeli M.D.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R Moghbeli M.D. 3455 WILKENS AVE 21229		
31. DATE FILED (Month, Day, Year): AUG 29 89	32. REGISTRAR'S SIGNATURE: Gwendolyn Hamilton	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24832
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): TERRY G. COUCH
2. DATE OF DEATH: MONTH 8 DAY 22 YEAR 89
3. TIME OF DEATH: 12 48 AM
4. SOCIAL SECURITY NUMBER: 419-12-2882
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 64 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-6-25
8. BIRTHPLACE (State or Foreign Country): Alabama
9a. FACILITY NAME (If not institution, give street and number): University of Maryland Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Kent
10c. CITY, TOWN OR LOCATION: Millington
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Box 340A
10f. ZIP CODE: 21651
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk
16b. KIND OF BUSINESS/INDUSTRY: State Highway Admin.
17. FATHER'S NAME (First, Middle, Last): Walton Kennon Couch
18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Narcissa Gibson
19a. INFORMANT'S NAME (Type/Print): Jean Couch
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 340A Millington, Md 21651
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Eastern Shore Veterans Cem.
20c. LOCATION — City or Town, State: Hurlock, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary B. Fellows
22. NAME AND ADDRESS OF FACILITY: Fellows Funeral Home P.O. Box 270 - Millington, Md. 21651

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CARDIO PULMONARY ARREST	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	MYOCARDIAL INFARCTION	18 days
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Frank Procaccino MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 8/22/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANK PROCACCINO 22 S. GREENE ST. UNIV OF Md. HOSPITAL BALTIMORE Md.
31. DATE FILED (Month, Day, Year): 8/22/89
32. REGISTRAR'S SIGNATURE: Thomas C. Heinemann

12

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR MARTIN G. GEORGULAS

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24833 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARTIN G. GEORGULAS			2. DATE OF DEATH (Month, Day, Year): 08 30 89	3. TIME OF DEATH: 528p M
4. SOCIAL SECURITY NUMBER: 213-03-9969	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 56 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11/26/33	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Bon Secours Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY: --	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: Lincoln Convalescent Ctr. 1217 W. Fayette St.		10f. ZIP CODE: 21223		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): none		16b. KIND OF BUSINESS/INDUSTRY: na
17. FATHER'S NAME (First, Middle, Last): George Georgulas, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Lagon		
19a. INFORMANT'S NAME (Type/Print): Anna Georgulas		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 414 Poole Rd., Westminster, Md. 21157		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Cremation, Inc.		20c. LOCATION — City or Town, State: Hampstead, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert K. Pritts Sr/mf ▶ Robert K. Pritts, Sr.		22. NAME AND ADDRESS OF FACILITY: 412 Washington Road Westminster, Md. 21157		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Septic Shock Syndrome 2° Gram Negative Bacteremia

DUE TO (OR AS A CONSEQUENCE OF): b. Urinary Tract infection

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. (R) Pneumonitis

DUE TO (OR AS A CONSEQUENCE OF): d. Acute Renal Failure

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cardiac Arrhythmias; Gram Mal Seplies; Acute Upper Gastrointestinal Bleeding

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D18711	29d. DATE SIGNED (Month, Day, Year) ▶ 8/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BERNARDO D. GONZALEZ JR.	Bon Secours Hospital 2000 W. Baltimore, Md. 21223	
31. DATE FILED (Month, Day, Year): SEP 1 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

3 237 51 22
GILL, ELEANOR C
03/30/

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24834

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELEANOR CATHERINE GILL			2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 1, 1989	3. TIME OF DEATH: 3:05 A M
4. SOCIAL SECURITY NUMBER: 219-58-9376	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 39 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): SEPT. 30, 1949	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1809 COBOURG COURT		10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FLORIST	16b. KIND OF BUSINESS/INDUSTRY: RETAIL FLOWERS.	
17. FATHER'S NAME (First, Middle, Last): THOMAS HARRY DRURY		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY BREHANY	
19a. INFORMANT'S NAME (Type/Print): ROBERT PATRICK GILL, SR.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1809 COBOURG CT., BALTIMORE, MARYLAND 21234	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SACRED HEART CEMETERY	20c. LOCATION — City or Town, State: BUSHWOOD, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward W. Brinsfield		22. NAME AND ADDRESS OF FACILITY: BRINSFIELD FUNERAL HOME P.O. BOX 279, LEONARDTOWN, MD. 20650	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heert failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel diseese or condition resulting in death) →	a. HYPOXIA	1 DAY
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentielly list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. BRONCHIOALVEOLAR CARCINOMA	6 MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF OEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: D. Draska MD	29c. LICENSE NUMBER: JHH#49137	29d. DATE SIGNED (Month, Day, Year): ▶ 9/1/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETEO CAUSE OF OEATH (ITEM 27) (Type, Print): DONALD J. DERASKA JHH 600 N. WOLFE ST. BALT MD 21205

31. DATE FILED (Month, Day, Year): 9/1/89 SEP 05 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24835

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WALTER J. GUTTERSON			2. DATE OF DEATH: MONTH 8 DAY 20 YEAR 89	3. TIME OF DEATH: 4:21 A M
4. SOCIAL SECURITY NUMBER: 127-14-7064	5. SEX: 1 [X] M 2 [ ] F	6. AGE (in yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9/15/98	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): HARBOR HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: ARNOLD		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 305 COLLEGE PARKWAY		10f. ZIP CODE: 21012		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesman		16b. KIND OF BUSINESS/INDUSTRY: Retail
17. FATHER'S NAME (First, Middle, Last): DAVID GUTTERSON		18. MOTHER'S NAME (First, Middle, Maiden Surname): MOLLIE PICKMAN		
19a. INFORMANT'S NAME (Type/Print): DAVID R. GUTTERSON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2207 Chesapeake Harbour Dr. E. Annapolis, MD 21403		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. CARMEL		20c. LOCATION — City or Town, State: BROOKLYN, NY
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas A Hardesty		22. NAME AND ADDRESS OF FACILITY: HARDESTY FUNERAL HOME 21401 12 RIDGELY AVE. ANNAPOLIS, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	20 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Cellulitis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] deBruyn M.D. House Staff		8/2/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Harbor Hospital Center 3001 S. Hanover St. Baltimore, MD 21230

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 28 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24836

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George Grover Harper
2. DATE OF DEATH (Month, Day, Year): 08 16 89
3. TIME OF DEATH: 20:50 M
4. SOCIAL SECURITY NUMBER: 213-20-7708
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 64 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6/21/25
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Reisterstown
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 302 Stonecastle Ave.
10f. ZIP CODE: 21136
10g. CITIZEN OF WHAT COUNTRY? USA.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW-II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Claims Adjuster
16b. KIND OF BUSINESS/INDUSTRY: Insurance
17. FATHER'S NAME (First, Middle, Last): George Grover Harper, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Leona Ashburn
19a. INFORMANT'S NAME (Type/Print): Mary E. Harper
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 302 Stonecastle Ave., Reisterstown, Md. 21136
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen Memorial Gardens
20c. LOCATION — City or Town, State: Finksburg, Md. 21048
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R Larry Nightingale
22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel, Owings Mills, Md. 21117

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Squamous Cell Ca Lung	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: A. Christe M.D.
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 08/16/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sinai Hospital
31. DATE FILED (Month, Day, Year): AUG 18 '89
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

2.

89 24837

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BILLIE J. JONES		2. DATE OF DEATH: AUG. 15, 1989	3. TIME OF DEATH: 1705p M
4. SOCIAL SECURITY NUMBER: 413-52-1920	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (If less than 1 yr. last birthday): 53 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH: 2-5-1936
8. BIRTHPLACE (State or Foreign Country): VIRGINIA			

9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSP	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH: BALT. CITY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: CECIL	10c. CITY, TOWN OR LOCATION: PORT DEPOSIT	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5 STAYMAN DRIVE	10f. ZIP CODE: 21904	10g. CITIZEN OF WHAT COUNTRY?	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HEAVY EQUIP. OPERATOR	16b. KIND OF BUSINESS/INDUSTRY: CONSTRUCTION	
17. FATHER'S NAME (First, Middle, Last): WESLEY CARPER JONES	16. MOTHER'S NAME (First, Middle, Maiden Surname): MAUDE ADA ELLER		
19a. INFORMANT'S NAME (Type/Print): JANET R. JONES	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 STAYMAN DR. PORT DEPOSIT, MD 21904		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ROSEBANK CEMETERY	20c. LOCATION — City or Town, State: RISING SUN, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert T. Foard	22. NAME AND ADDRESS OF FACILITY: R.T. FOARD FUNERAL HOME RISING SUN, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Aspiration	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURRED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. Nazem MD (Fellow Resident)	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. Nazem Dept of CT. Surgery U. of Md Hospital			
31. DATE FILED (Month, Day, Year): AUG 18 '89	32. REGISTRAR'S SIGNATURE: Julia Tarleton Rhodes		

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 4 may be retained by the funeral director as the burial-transit permit. Pages 1, 2, 3 should

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified and state.

7

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24838 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SHIRLEY JONES
2. DATE OF DEATH: MONTH 8 DAY 15 YEAR 89
3. TIME OF DEATH: 1140 AM M
4. SOCIAL SECURITY NUMBER: 227-52-5488
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 52 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6-6-37
8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): GOOD SAMARITAN
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD
9c. COUNTY OF DEATH: BALTO CITY

RESIDENCE OF DECEDENT

10a. STATE: DELAWARE
10b. COUNTY: Sussex
10c. CITY, TOWN OR LOCATION: LINCOLN
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: RD 2 BOX 392
10f. ZIP CODE: 19960
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Line Production Worker
16b. KIND OF BUSINESS/INDUSTRY: Dental Supply Co.
17. FATHER'S NAME (First, Middle, Last): James Clark
18. MOTHER'S NAME (First, Middle, Maiden Surname): Katie Trautman
19a. INFORMANT'S NAME (Type/Print): Cynthia Duker
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 114 W. W. 3rd St, Milford, De 19963
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bennie L Smith
22. NAME AND ADDRESS OF FACILITY

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CARDIAC ARREST	30 MIN
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	EXANGUINATION (JEHOVAH'S WITNESS)	1 HOUR
DUE TO (OR AS A CONSEQUENCE OF):		
c.	RENAL CELL CARCINOMA	8 > 1 yr
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 8
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: James K Smolen M.
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): ▶ 8-15-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAMES K. SMOLEN
31. DATE FILED (Month, Day, Year): AUG 28 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24839 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Janey Baublitz, A/K/A Jenny Kalatzis		2. DATE OF DEATH (Month / Day / Year): 08 / 10 / 89	3. TIME OF DEATH: 5:55 P M
4. SOCIAL SECURITY NUMBER: 213-01-9856	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 31 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 04/05/58
8. BIRTHPLACE (State or Foreign Country): Md.			
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: Baltimore	
RESIDENCE OF DECEDENT			
10a. STATE: Md	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 422 Bonsal St.		10f. ZIP CODE: 21224	10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Melvin Baublitz		18. MOTHER'S NAME (First, Middle, Maiden Surname): Hilda Mae	
19a. INFORMANT'S NAME (Type/Print): Redia F. Harrington	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 527 S. Oldham St., Balto., Md. 21224		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star Cemetery	20c. LOCATION — City or Town, State: Balto. Co., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Gary L. Kaufman Funeral Homes, 5695 Main Street, Elkridge, Md. 21227		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	~~Liver Failure~~ DIC	1 week
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Renal Failure	2 weeks
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Pneumania	1 week
DUE TO (OR AS A CONSEQUENCE OF):		
d.	Liver failure	2 weeks

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated.
2 ☐ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
James Kaiser	D76381	▶ 8/12/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Harry Kaplan MD 4940 Eastern Ave. Balt. Maryland.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 16 89	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24840 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVELYN L. KENNEDY
2. DATE OF DEATH: MONTH 8 DAY 17 YEAR 89
3. TIME OF DEATH: 2-05 PM
4. SOCIAL SECURITY NUMBER: 215-34-9394
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 08/30/16
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3107 FOSTER AVE
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): JOHN BOSLEY
18. MOTHER'S NAME (First, Middle, Maiden Surname): RACHEL L. HOLT
19a. INFORMANT'S NAME (Type/Print): RACHAEL DEERE
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 HAMMAKLEE RD. GLEN BURNIE, MD. 21061
20a. METNOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GLEN HAVE MEM. PARK
20c. LOCATION — City or Town, State: A.A. CO. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas J. Skarda Jr.
22. NAME AND ADDRESS OF FACILITY: THOMAS J. SKARDA 2829 HUDSON ST.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Septicemia
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Peritonitis
DUE TO (OR AS A CONSEQUENCE OF):
c. Perforation of Colon secondary to diverticulitis
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: N/A
29d. DATE SIGNED (Month, Day, Year): ▶ 8/17/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Y.K. SHETTY, Church Hospital, 100 N. Broadway, BALT, MD 21231
31. DATE RECEIVED (Month, Day, Year): AUG 21 89
32. REGISTRAR'S SIGNATURE: Lora Davidson-Randall

DNMN-16 Rev 1/89

89 24841

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anthony Launi				2. DATE OF DEATH (Month, Day, Year): 8 23 89	3. TIME OF DEATH: 3:15 A M
4. SOCIAL SECURITY NUMBER: 579-20-4799	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JULY 15, 1922	8. BIRTHPLACE (State or Foreign Country): WASHINGTON, D.C.
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: BETHESDA	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 9601 BELLEVUE DRIVE	10f. ZIP CODE: 20814	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 8+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ORAL SURGEON	16b. KIND OF BUSINESS/INDUSTRY: DENTAL/PRIVATE PRACTICE

17. FATHER'S NAME (First, Middle, Last): GUISEPPE LAUNI	18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSA LaMARTINA
19a. INFORMANT'S NAME (Type/Print): JOSEPH D. LAUNI	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 610 WHISPERING WIND COURT, GAITHERSBURG, MD 20877

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FT. LINCOLN	20c. LOCATION — City or Town, State: BRENTWOOD, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Aspiration Pneumonia	1 wk
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Creutzfeldt-Jakob disease	4 mo
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] Elfont MD	29c. LICENSE NUMBER JHH #E9507	29d. DATE SIGNED (Month, Day, Year) ▶ 8/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert Elfont Johns Hopkins Hospital

31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15+1

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24842

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DAVID L LANHAM — David Lee Lanham	2. DATE OF DEATH: MONTH 8 DAY 29 YEAR 89	3. TIME OF DEATH: 0654 AM	
4. SOCIAL SECURITY NUMBER: 578-70--0383	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 36 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11-05-52
8. BIRTHPLACE (State or Foreign Country): Washington,D.C.			
9a. FACILITY NAME (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD	9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Brandywine	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7708 Dyson Road	10f. ZIP CODE: 20613	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Grd. — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpet Installer	16b. KIND OF BUSINESS/INDUSTRY: Retail Carpet Company
17. FATHER'S NAME (First, Middle, Last): Lawrence G. Lanham, Jr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Sylvia E. Banks	
19a. INFORMANT'S NAME (Type/Print): Mrs. Donna Morrow	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2345 Wakefield Cr., Waldorf, MD 20602	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Trinity Memorial Gardens	20c. LOCATION — City or Town, State: Waldorf, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: The Huntt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland 20604-0156	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. HEPATIC COMA	2 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. HEPATIC FAILURE	4-6 months
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. PORTAL HYPERTENSION	> 1 year
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Cirrhosis	> 1 year

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

h/o alcohol abuse

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: UNIVERSITY OF MARYLAND — 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one):
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Marcos A Ugarte MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARCOS A. UGARTE 22 S. GREEN ST BALTO MD 21210

31. DATE FILED (Month, Day, Year): AUG 31 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24843

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gladys Loretta Myers			2. DATE OF DEATH (Month, Day, Year): 8-20-89	3. TIME OF DEATH: 7:32PM M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 6,1910	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): University Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: ----------

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Williamsport	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt.1 Box#229		10f. ZIP CODE: 21795	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Walter Christman Stenger		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margie May Hawbaker	
19a. INFORMANT'S NAME (Type/Print): Kenneth A.Myers		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): (item 10 above)	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Greenlawn Memorial Park	20c. LOCATION — City or Town, State: Williamsport,MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: OSBORNE FUNERAL HOMES P.O.Box # 348 Williamsport,MD 21795	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
☒ YES 2 ☐ NO	☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-20-89	28b. TIME OF INJURY: 11:58A	28c. INJURY AT WORK? 1 ☐ YES ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: Passenger in auto/auto impact
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rt. 68 & Governors Land Blvd. Washington County, Maryland

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-21-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell,M.D. 111 Penn Street,Baltimore,MD 21201 vc

31. DATE FILED (Month, Day, Year): AUG 22 89	32. REGISTRAR'S SIGNATURE: Jackie Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24844
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Eleanor MATHI			2. DATE OF DEATH: Month 8, Day 22, Year 89	3. TIME OF DEATH: 19:10 M
4. SOCIAL SECURITY NUMBER: 213-58-7223	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 59 YRS. (If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Mar. 8, 1930	8. BIRTHPLACE (State or Foreign Country): India
9a. FACILITY NAME (If not institution, give street and number): Shock Trauma University		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Columbia		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 6566 Beechwood Drive		10f. ZIP CODE: 21046		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Indian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1-12; College (1-4 or 5+): Jr. College	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Office Secty.		16b. KIND OF BUSINESS/INDUSTRY: Columbia Union College	
17. FATHER'S NAME (First, Middle, Last): T.V. Zachariah			18. MOTHER'S NAME (First, Middle, Maiden Surname): Jamima Arunanayagan	
19a. INFORMANT'S NAME (Type/Print): David Mathi		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6566 Beechwood Dr. Columbia, Md. 21046		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): George Washington Cemetery		20c. LOCATION — City or Town, State: Adelphi, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home, 11800 N.H. Ave., Silver Spring, Md. 20904		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple organ failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. ARDS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Bekele Afessa, M.D.	D35997	▶ 8/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 22 S. Green St. Bekele Afessa, MD Baltimore, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 '89	Julia Davidson-Randall

DHMH-18 Rev 1/89

10

89 24845

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
MEHDIA	Ahmed	Mohammed	AUGUST 23, 1989	9:53 P M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
None	1 ☐ M 2 ☒ F	57 YRS.			July 15, 1932	Addis Ababa, Eth.

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
THE JOHNS HOPKINS HOSPITAL	BALTIMORE CITY	BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Montgomery	Silver Spring,	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
8600 - 16th Street	20910	ETHIOPIA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
6		Housewife	Own Home

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mohammed Ahmed	Zubieda Yusef

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Hussien Ahmed	Same as #10

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Addis Ababa Cemetery	Addis Ababa, Ethiopia

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ [signature]	DeVol Funeral Home 2222 Wisc. ave., N.W., Wash. D.C. 20007

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	24hrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Hepatic Failure	7 days
	c. DUE TO (OR AS A CONSEQUENCE OF): Obstructive cholangitis	10 years
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 5 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 5 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature], MD		▶ 8/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kenneth Covinsky Johns Hopkins Hospital

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 '89	Julia Davidson-Randall

DHMH-15 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 24846

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HARRY Clay PURCELL			2. DATE OF DEATH (Month, Day, Year): 8 - 31 - 89	3. TIME OF DEATH: 945 A M
4. SOCIAL SECURITY NUMBER: 216-44-2504	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 85 YRS. IF UNDER 1 YEAR: MONTHS — DAYS — IF UNDER 24 HRS.: HOURS — MIN. —	7. DATE OF BIRTH (Month, Day, Year): 10-27-03	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Beverly Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH: Balto. Md.	9c. COUNTY OF DEATH: City	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Pikesville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 202 Oak Ave		10f. ZIP CODE: 21208	10g. CITIZEN OF WHAT COUNTRY? Usa.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4 or 5 +):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Policeman	16b. KIND OF BUSINESS/INDUSTRY: Law Enforcement	
17. FATHER'S NAME (First, Middle, Last): John James Purcell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Carter		
19a. INFORMANT'S NAME (Type/Print): Lillie C. Purcell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 202 Oak Ave., Pikesville, Md. 21208		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery	20c. LOCATION — City or Town, State: Pikesville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: H. J. Eckhardt		22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel Owings Mills, Md. 21117		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	PNEUMONIA, ASPIRATION	1 WEEK
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	DECREASED LEVEL OF CONSCIOUSNESS	''' WEEK
DUE TO (OR AS A CONSEQUENCE OF):		
c.	ANOXIC BRAIN DAMAGE	''' WEEK
DUE TO (OR AS A CONSEQUENCE OF):		
d.	CARDIO PULMONARY ARREST	''' WEEK

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY — M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A J Lucco ATTEND MD	29c. LICENSE NUMBER: D30951	29d. DATE SIGNED (Month, Day, Year): 8-31-89	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A J Lucco, MD 2434 W. Belvedere Ave Balto 21215-5299			
31. DATE FILED (Month, Day, Year): AUG 31 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

OHMH-16 Rev 1/89

Items:28a,28b per ME G-656

10-6-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24847 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lucille M Rowe			2. DATE OF DEATH (Month, Day, Year): 8-22-89	3. TIME OF DEATH: 11:58PM M
4. SOCIAL SECURITY NUMBER: 223 - 24 - 4135	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 14,1922	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): University Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Laurel		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 606 Talbott Ave		10f. ZIP CODE: 20707		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 7; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Charles Swearengin			18. MOTHER'S NAME (First, Middle, Maiden Surname): Cora Smith	
19a. INFORMANT'S NAME (Type/Print): Wilson Rowe		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 606 Talbott Ave Laurel, Maryland 20707		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery		20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Donaldson Funeral Home P.A. 313 Talbott Ave Laurel, Maryland 20707		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Head injuries	
	a. DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO
INSPECTION	

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-22-89	28b. TIME OF INJURY: 3:30 am	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
	28d. DESCRIBE HOW INJURY OCCURED: Subject fell down stairs		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): House	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 13604 Engleman Dr.,Laurel, Prince Georges County,Maryland	

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	OCME	▶ 8-23-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes,M.D. 111 Penn Street,Baltimore,Maryland 21201 vc

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24848

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES W. SCRUGGS			2. DATE OF DEATH: MONTH 08 DAY 26 YEAR 89	3. TIME OF DEATH: 2206 M
4. SOCIAL SECURITY NUMBER: 215-30-8938	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 54 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 01 02 35	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Hampstead		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1222 Woodland Ct.		10f. ZIP CODE: 21074		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): School Teacher		16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Robert F. Scruggs		18. MOTHER'S NAME (First, Middle, Maiden Surname): Hazel Robertson		
19a. INFORMANT'S NAME (Type/Print): Mrs. Nancy W. Scruggs		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1222 Woodland Ct., Hampstead, Md. 21074		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park		20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jerry D. Eline		22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home, 934 S. Main St. Hampstead, Md. 21074		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. ACUTE PERITONITIS, GRAM NEGATIVE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CIRRHOSIS, LIVER	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William J Hicken MD	29c. LICENSE NUMBER: D04964	29d. DATE SIGNED (Month, Day, Year) ▶ 8/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WILLIAM J HICKEN MD. ST AGNES HOSPITAL

31. DATE FILED (Month, Day, Year): AUG 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24849
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FANNIE STANTON			2. DATE OF DEATH: MONTH 8 DAY 12 YEAR 1989	3. TIME OF DEATH: 3:00A M
4. SOCIAL SECURITY NUMBER: 219 34 4027	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 96 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6/19/93	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Maryland		9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Ellicott City	10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3800 OLD COLUMBIA PIKE		10f. ZIP CODE: 21043	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNK. College (1-4 or 5+): UNK.	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: OWN	
17. FATHER'S NAME (First, Middle, Last): JOHN FLETCHER		18. MOTHER'S NAME (First, Middle, Maiden Surname): UNK.	
19a. INFORMANT'S NAME (Type/Print): GLADYS CROSS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3800 OLD COLUMBIA PIKE E.C. 21043	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Doisy Meth Ch. Cem	20c. LOCATION — City or Town, State: WOODBINE, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Julia Davidson Black M0533		22. NAME AND ADDRESS OF FACILITY: SIACK F.H. PO BOX 248 E.C. 21043	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ee cerdiec or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal failure — 25 days.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Sepsis

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic Cardio Vascular Disease.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S.B.S. Prasad M.D House Staff	29c. LICENSE NUMBER: N/A	29d. DATE SIGNED (Month, Day, Year): 8/12/89	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S.B.S. Prasad M.D 300 Harbor Hospital center, Baltimore MD 21230			
31. DATE FILED (Month, Day, Year): AUG 15 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24850
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELWOOD C. WILHELM
2. DATE OF DEATH — MONTH: 8 DAY: 14 YEAR: 89
3. TIME OF DEATH: 1:45 AM
4. SOCIAL SECURITY NUMBER: 213-28-873
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1-15-18
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Upperco
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3207 Mt. Carmel Road
10f. ZIP CODE: 21155
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerio Rican, etc.) 1 ☐ YES ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): Elementary — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Equipment Operator
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATNER'S NAME (First, Middle, Last): Edward Wilhelm
18. MOTHER'S NAME (First, Middle, Maiden Surname): Addie Harris
19a. INFORMANT'S NAME (Type/Print): Mrs. Dorothy E. Wilhelm
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3207 Mt. Carmel Road, Upperco, Md. 21155
20a. METNOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Forest Cemetery
20c. LOCATION — City or Town, State: Upperco, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jerry D. Eline
22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home, 934 S. Main St. Hampstead, Maryland 21074

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Chronic Obstructive Pulmonary Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATN: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 8.14.89
30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Chow, Mei-Yee M.D. Good Samaritan Hospital
31. DATE FILED (Month, Day, Year): AUG 15 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24851
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH Month	Day	Year	3. TIME OF DEATH		
BENSON	E.	BROWN		8	25	1989	12:05	A M	
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)		
220-28-6846	1 ☒ M 2 ☐ F	58 YRS.			April 02, 1931		Maryland		
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH					
Southbound Rt. 4		Sunderland		Calvert					
RESIDENCE OF DECEDENT									
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?					
Maryland	Calvert	Huntingtown		1 ☐ YES 2 ☒ NO					
10e. STREET AND NUMBER		10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?					
6010 Steven Reid Road		20639		USA					
11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. RACE — American Indian, Black, White, etc.					
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify:		Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12): 0-4	College (1-4 or 5+):	Labor							
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)							
Carl J. Brown		Nancy Brown							
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Helen Mackall		3455 Evans Rd. Huntingtown, Md 20639							
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State					
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		St. Edmonds Church Cemetery		Sunderland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY							
▶ Spencer E. Sewell		Sewell Funeral Home		1451 Dares Beach Rd Prince Frederick, Md					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) scene

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	8-24-89	11:56P M	1 ☐ YES 2 ☒ NO	Pedestrian struck by auto.
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) road			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Southbound Rt. 4, Sunderland, MD

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	OCME	▶ 8-25-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles P. Kokes, M.D. 111 Penn St., Balto., MD 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 28 1989	Julia Davidson-Randall

DNMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 21,852

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Beatrice Ethel BLEND			2. DATE OF DEATH (Month, Day, Year): August 30, 1989	3. TIME OF DEATH: 0320 M
4. SOCIAL SECURITY NUMBER: 579 28 2507	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-4-1897	8. BIRTHPLACE (State or Foreign Country): ENGLAND
9a. FACILITY NAME (If not Institution, give street and number): Calvert Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Prince Frederick		9c. COUNTY OF DEATH: Calvert

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: St. Leonard	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6621 Dawkins Ct.		10f. ZIP CODE: 20685	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): dispatcher	16b. KIND OF BUSINESS/INDUSTRY: US Gov't - Naval Research	
17. FATHER'S NAME (First, Middle, Last): Thomas Wilson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Esther Snarey	
19a. INFORMANT'S NAME (Type/Print): Naomi V. Stratton	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as 10 above		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Southern Mem. Gardens	20c. LOCATION — City or Town, State: Dunkirk (Calvert) MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] RFH	22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home Owings, MD 20736		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	1 day
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Ischemic colitis	6 mos.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] M.D.	D26010	▶ 8/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Craig Jeschke, M.D. Owings, Maryland 20736

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 1 1989	Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24853
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
John	M	Dahlquist Jr.	August 23, 1989	0605 M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
248-78-9298	1 [X] M 2 [ ] F	42 YRS.			3/12/47	Florida

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Calvert Memorial Hospital	Prince Frederick	Calvert

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Calvert	Lusby	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
21 Pawnee Lane	20657	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	5+	Atomic Engineer	Atomic Energy

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
John M. Dahlquist Sr.	Sarah Katherine Cantrell

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William G. Dahlquist	Rockland Mass. 02370

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	St. Patricks Cemetery	Rockland Massachuetts

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Bolton Rausch	Quealy & Son Funeral Home 116 Adams Street, Abington, Massachuetts 02351

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pulmonary Edema	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cirrhosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Pancreatitis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ascites

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Wayne K. Zinner MD	D34990	8/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Wayne K. Zinner MD 262 C Prince Frederick MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
8/24/89	Wayne K. Zinner MD

AUG 25 1989 Julia Davidson-Randall

DNMN-16 Rev 1/89

15

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24854

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Clyde Peter Dove			2. DATE OF DEATH (Month, Day, Year): 08 / 29 / 89	3. TIME OF DEATH: 1230P.M. M
4. SOCIAL SECURITY NUMBER: 219-01-3803	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 09-15-02	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Calvert Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Prince Frederick		9c. COUNTY OF DEATH: Calvert

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: Lusby	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Box 45, Olivet Road		10f. ZIP CODE: 20657	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waterman	16b. KIND OF BUSINESS/INDUSTRY: Seafood	
17. FATHER'S NAME (First, Middle, Last): Peter B. Dove		18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Ramsey	
19a. INFORMANT'S NAME (Type/Print): Ray P. Dove	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 45, Olivet Rd; Lusby, Maryland 20657		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Solomons UMC Cemetery	20c. LOCATION — City or Town, State: Solomons, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ BRausch	22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home, 4405 Broomes Isl Rd; Port Republic, Md 20676		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MYOCARDIAL INFARCTION	FEW MINUTES
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CARDIAC ARRHYTHMIAS	5 YEARS
DUE TO (OR AS A CONSEQUENCE OF):		
	c. COPD	10 YEARS
DUE TO (OR AS A CONSEQUENCE OF):		
	d. HYPERTENSION	15 YEARS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Scam Mathew MD	29c. LICENSE NUMBER: D36969	29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S Mathew, M.D. Prince Frederick, Maryland		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24855
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Matilda Gross					2. DATE OF DEATH: MONTH 08 DAY 24 YEAR 89	3. TIME OF DEATH: 04:03 a M
4. SOCIAL SECURITY NUMBER: 217-01-9300	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 02/16/11	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Calvert Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Pr. Frederick, Md.		9c. COUNTY OF DEATH: Calvert	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: St. Leonard Md.			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO	
10e. STREET AND NUMBER: Box 10-E		10f. ZIP CODE: 20685			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0-7 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic			16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Moses Johnson					18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Myers	
19a. INFORMANT'S NAME (Type/Print): Rosie Gantt			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 853 Lusby, Md 20657			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Johns Church Cemetery		20c. LOCATION — City or Town, State: Lusby, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Spencer L Sewell			22. NAME AND ADDRESS OF FACILITY: Sewell Funeral Home		1451 Dares Beach Rd. Prince Frederick, Md	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the desth. Do not enter the mode of dying, such ee cerdiec or reepiratory arrest, shock, or heert failure. Liet only one ceuse on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → e. METASTATIC BREAST CANCER

DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly liet conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D26358	▶ 8-24-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
BOX 262-C PRINCE FREDERICK, MD - 20678

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 28 1989	Julia Davidson-Rendell

2

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24856 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Charlottte	GANTT	August 29, 1989	1530 M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
—	1 ☐ M 2 ☒ F	85 YRS.			Jan. 12-04	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Calvert Memorial Hospital	Prince Frederick	Calvert

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Calvert	Port Republic	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
Box 66-B	20676	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
0-5		Nurse	

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
William Golder	Roberta Wallace

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Helen Jackson	P.O. Box 494 Lusby, Maryland 20657

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Brooks Church Cemetery	St Leonard, Md

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Gladys A. Sewell	Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, Md

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	1 d
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Congestive Cardiomyopathy	1 week
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- Severe Hyperkalemia
- Chronic Degenic Brain syndrome

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D-25519	▶ 08-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
Prince Frederick, Maryland 20678

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

4

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24857
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDNA JACKS JONES			2. DATE OF DEATH (Month, Day, Year): 9 / 4 / 89	3. TIME OF DEATH: 8:00 p M
4. SOCIAL SECURITY NUMBER: 214-36-2996	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 5, 1896	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Calvert Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Prince Frederick, Md.		9c. COUNTY OF DEATH: Calvert

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: Huntingtown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3899 Hunting Creek Road		10f. ZIP CODE: 20639	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0-7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): House-Wife	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Asbury Jacks		18. MOTHER'S NAME (First, Middle, Maiden Surname): Maria Gross	
19a. INFORMANT'S NAME (Type/Print): Ethel Adams	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 570 Grovers Turn Rd. Owings, Md 20736		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Patuxent Church Cemetery	20c. LOCATION — City or Town, State: Huntingtown, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Spencer E. Sewell	22. NAME AND ADDRESS OF FACILITY: Sewell Funeral Home	1451 Dares Beach Rd. Prince Frederick, Md	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebral Hemorrhage	3 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cerebral aneurism	years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D29657	29d. DATE SIGNED (Month, Day, Year) ▶ 9/5/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles A. Judge, M.D.		
31. DATE FILED (Month, Day, Year): SEP 7 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24858
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
Morsell,	Pearl	H.	08/28/89	0458 a M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
217-28-8281	1 ☐ M 2 ☒ F	75 YRS.			08/16/14	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Calvert Mem. Hospital	Pr. Frederick, Md	Calvert

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Calvert	Huntingtown	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
3195 Plum Point Rd.	20639	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
0-7		House-Wife	

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Samuel Harris	Dinnie Smith

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rachel Jones	3195 Plum Point Rd. Huntingtown, Md 20639

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Plum Point Chr. Cemetery	Huntingtown, Md

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Spencer E. Sewell	Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, Md

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sinus Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hyperkalemia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Renal Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1) Diabetes Mellitus 2) Hypertension
3) Severe Peripal Vascular Disease

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D33123	▶ 8-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Jonathan Lowenthal, M.D. Prince Frederick, Maryland

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24859

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anthony Charles Passero			2. DATE OF DEATH (Month, Day, Year): August 27, 1989	3. TIME OF DEATH: 1300 M
4. SOCIAL SECURITY NUMBER: 725 01 3915	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5-20-29	8. BIRTHPLACE (State or Foreign Country): Wash., DC
9a. FACILITY NAME (If not institution, give street and number): Calvert Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Prince Frederick	9c. COUNTY OF DEATH: Calvert	
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: North Beach	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 8910 Dayton Ave.		10f. ZIP CODE: 20714	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Upholsterer	16b. KIND OF BUSINESS/INDUSTRY: Self employed upholstery		
17. FATHER'S NAME (First, Middle, Last): Anthony Paul Passero		16. MOTHER'S NAME (First, Middle, Maiden Surname): Jane Mary Bolger		
19a. INFORMANT'S NAME (Type/Print): Linda Yeffman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 911 Sligo Creek Pky. Takoma Park, MD 20912		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery	20c. LOCATION — City or Town, State: Brentwood, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William R. Gross		22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home Owings, MD 20736		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not antar the mode of dying, such aa cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Atherosclerotic Coronary Artery Disease	6 yrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER: D 26010	29d. DATE SIGNED (Month, Day, Year): ▶ 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Craig Jeschke, M.D.	Prince Frederick, Maryland		
31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

15

DHMH-18 Rev 1/89

89 24860

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marion Elizabeth RUSK			2. DATE OF DEATH (Month, Day, Year): August 28, 1989	3. TIME OF DEATH: 850 M
4. SOCIAL SECURITY NUMBER: 358 10 5252	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 2-11-20	8. BIRTHPLACE (State or Foreign Country): GA
9a. FACILITY NAME (If not institution, give street and number): Calvert Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Prince Frederick		9c. COUNTY OF DEATH: Calvert

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Rosehaven	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6897 Charleston Ave.		10f. ZIP CODE: 20714	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife	16b. KIND OF BUSINESS/INDUSTRY: -	
17. FATHER'S NAME (First, Middle, Last): Osman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Dora	
19a. INFORMANT'S NAME (Type/Print): Leo D. Rusk	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11837 Gainsborough Rd. Potomac, MD 20854		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory	20c. LOCATION — City or Town, State: Alexandria, VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W. Michael Rogers RFH	22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home Owings MD Rausch F.H. Owings, MD 20736		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute Myocardial infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive lung disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Zahir Yousaf	29c. LICENSE NUMBER: D 27189	29d. DATE SIGNED (Month, Day, Year): ▶ 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Zahir Yousaf, M.D. Huntingtown, Maryland 20639

31. DATE FILED (Month, Day, Year): AUG 31 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Pondexter

ONMN-16 Rev 1/89

16

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24861
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RODERICK JOSEPH SAUL
2. DATE OF DEATH: MONTH 09 DAY 02 YEAR 89
3. TIME OF DEATH: 1546 P.M.M
4. SOCIAL SECURITY NUMBER: 577 20 4741
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 63 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-2-26
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): CALVERT MEMORIAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: PR. FREDERICK
9c. COUNTY OF DEATH: CALVERT

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Calvert
10c. CITY, TOWN OR LOCATION: Huntingtown
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1770 Plum Point Rd.
10f. ZIP CODE: 20639
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver
16b. KIND OF BUSINESS/INDUSTRY: Transportation
17. FATHER'S NAME (First, Middle, Last): Albert Francis Saul
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsie Agnes Harvey
19a. INFORMANT'S NAME (Type/Print): Dorothy A. Saul
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as 10 above
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MD Veterans Cem.
20c. LOCATION — City or Town, State: Cheltenham (PG) MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ N. Michael Phipps RFH
22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home Owings, MD 20736

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIO PULMONARY ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ATHEROSCLEROTIC HEART DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Mukatur MD
29c. LICENSE NUMBER: D25425
29d. DATE SIGNED (Month, Day, Year): ▶ 9/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MUKESH MATHUR, M.D. PR. FREDERICK, MARYLAND
31. DATE FILED (Month, Day, Year): SEP 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

89 24862

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLARD CLIFTON WARD, SR.
2. DATE OF DEATH (Month, Day, Year): AUGUST 20, 1989
3. TIME OF DEATH: 12:22A M
4. SOCIAL SECURITY NUMBER: 219 16 1176
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 62 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-4-26
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): CALVERT MEMORIAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: PRINCE FREDERICK
9c. COUNTY OF DEATH: CALVERT

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Calvert
10c. CITY, TOWN OR LOCATION: North Beach
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4110 1st Street
10f. ZIP CODE: 20714
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Proprietor-well drilling
16b. KIND OF BUSINESS/INDUSTRY: Well drilling
17. FATHER'S NAME (First, Middle, Last): Willard Spicknall Ward
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lorena Pauline Dodge
19a. INFORMANT'S NAME (Type/Print): Sue Ward
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as 10 above
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Harmony UMC
20c. LOCATION — City or Town, State: Owings (Calvert) MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] RFH
22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home Owings, MD 20736

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic arteriosclerotic
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic Hypertension
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D12705
29d. DATE SIGNED (Month, Day, Year): 8/20/1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EMAD AL BANNA, M.D. PRINCE FREDERICK, MD. 20678

31. DATE FILED (Month, Day, Year): AUG 24 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

12

1 - FOR STATE REGISTRAR DAVID S. WELLS

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24863 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): David S. Wells			2. DATE OF DEATH (Month, Day, Year): 8 14 89	3. TIME OF DEATH: 0500 M
4. SOCIAL SECURITY NUMBER: 218 12 9017	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 8-30-10
8. BIRTHPLACE (State or Foreign Country): MD				
9a. FACILITY NAME (If not institution, give street and number): 6821 Briscoe's Turn Road	9b. CITY, TOWN OR LOCATION OF DEATH: Owings	9c. COUNTY OF DEATH: Calvert		

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: Owings	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 6821 Briscoe's Turn Rd.	10f. ZIP CODE: 20736	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer	16b. KIND OF BUSINESS/INDUSTRY: Agriculture	
17. FATHER'S NAME (First, Middle, Last): John David Wells	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Agnes Cox		
19a. INFORMANT'S NAME (Type/Print): David E. Wells	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 125 Owings, MD 20736		
20a. METHOD OF DISPOSITION: X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Harmony UMC Cemetery	20c. LOCATION — City or Town, State: Owings (Calvert) MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: M. Michael Boyd LFH	22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home, Owings, MD 20736		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary artery disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D22615	29d. DATE SIGNED (Month, Day, Year): ▶ 8-19-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Ronald J. Ross MD Prince Fredrick MD 20678		
31. DATE FILED (Month, Day, Year): AUG 24 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24864
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sr. M. Bernadette Grawe
2. DATE OF DEATH (Month, Day, Year): Aug. 13, 1989
3. TIME OF DEATH: 5 AM
4. SOCIAL SECURITY NUMBER: 216-54-7670
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 93 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 1/14/96
8. BIRTHPLACE (State or Foreign Country): Germany
9a. FACILITY NAME (If not institution, give street and number): St. Gertrude's Priory
9b. CITY, TOWN OR LOCATION OF DEATH: Ridgely
9c. COUNTY OF DEATH: Caroline

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Caroline
10c. CITY, TOWN OR LOCATION: Ridgely
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 312
10f. ZIP CODE: 21660
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nun
16b. KIND OF BUSINESS/INDUSTRY: Religion
17. FATHER'S NAME (First, Middle, Last): Heinrich Grawe
18. MOTHER'S NAME (First, Middle, Maiden Surname): Gertrude Niggemeir
19a. INFORMANT'S NAME (Type/Print): St. Gertrude's Priory
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Ridgely, MD 21660
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): St. Gertrude's Cemetery
20c. LOCATION — City or Town, State: Ridgely, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Fleegle-Helfenbein Funeral Home P.O. Box 160, Greensboro, MD 21639

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	MYOCARDIAL INFARCTION	ACUTE
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	ARTERIOSCLEROTIC CARDIOVASC DISEASE	chronic
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Christian Jensen MD
29c. LICENSE NUMBER: D14664
29d. DATE SIGNED (Month, Day, Year): ▶ 8/20/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): P.O. BOX 690, DENTON MD 21629
31. DATE FILED (Month, Day, Year): SEP 12 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24865
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permits. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SHAWN David ADAMS

2. DATE OF DEATH (Month, Day, Year): August 10, 1989

3. TIME OF DEATH: 11 P M

4. SOCIAL SECURITY NUMBER: 214-02-5348

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 13 YRS.

IF UNDER 1 YEAR — MONTHS: 4 DAYS: 19 | IF UNDER 24 HRS. — HOURS: MIN.:

7. DATE OF BIRTH (Month, Day, Year): 3/21/76

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): 2460 Braddock Road

9b. CITY, TOWN OR LOCATION OF DEATH: Mt. Airy

9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Carroll

10c. CITY, TOWN OR LOCATION: Mt. Airy

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 2460 Braddock Road

10f. ZIP CODE: 21771

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 7 yrs.
College (1-4 or 5+): None

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): W. David Adams

18. MOTHER'S NAME (First, Middle, Maiden Surname): Carol Jean White

19a. INFORMANT'S NAME (Type/Print): W. David Adams

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2460 Braddock Rd. Mt. Airy, Md. 21771

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crestlawn Mem. Gardens

20c. LOCATION — City or Town, State: Howard Co., Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles A. Burrier, II

22. NAME AND ADDRESS OF FACILITY: Burrier Funeral Home
Winfield, Maryland 21784

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. RHABDOMYOSARCOMA, METASTATIC — 1YR.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. _____ DUE TO (OR AS A CONSEQUENCE OF):
c. _____ DUE TO (OR AS A CONSEQUENCE OF):
d. _____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year):

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED:

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ruth E. Rueda MD

29c. LICENSE NUMBER: D06726

29d. DATE SIGNED (Month, Day, Year): ▶ 8/11/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):

31. DATE FILED (Month, Day, Year): AUG 14 '89

32. REGISTRAR'S SIGNATURE: Jean Harrison-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24866
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hilda Mengel Arnold				2. DATE OF DEATH (Month, Day, Year): 8 21 1989	3. TIME OF DEATH: 6:10 M
4. SOCIAL SECURITY NUMBER: 220-01-4508 A	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12-2-1901	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Blizzards Care Home			9b. CITY, TOWN OR LOCATION OF DEATH: Westminster, Md.		9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1207 Deer Park Rd.		10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Elementary; College (1-4 or 5+): -	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Packer	16b. KIND OF BUSINESS/INDUSTRY: Black & Decker	
17. FATHER'S NAME (First, Middle, Last): Charles Mengel		18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Ward	
19a. INFORMANT'S NAME (Type/Print): Naomi Belleson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1207 Deer Park Rd. Westminster, Md. 21157	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Trinity Lutheran Church	20c. LOCATION — City or Town, State: Westminster
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas D. Fletcher		22. NAME AND ADDRESS OF FACILITY: 254 East Main Street Westminster, Md. 21157	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ASCVD

DUE TO (OR AS A CONSEQUENCE OF):

c. Old - advanced aging

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: N/A

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — (At home, farm, street, factory, office building, etc. Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John W. Middleton	29c. LICENSE NUMBER: D25743	29d. DATE SIGNED (Month, Day, Year): 8-22-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 625 G Balt Blvd Westminster Md 21157

31. DATE FILED (Month, Day, Year): AUG 22 '89	32. REGISTRAR'S SIGNATURE: Richard Davidson Pindell

DHMH-16 Rev 1/89

89 24867

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VIVIAN FARNER FRY BURRIS
2. DATE OF DEATH (Month, Day, Year): Aug 26 1989
3. TIME OF DEATH: 12 NOON PM
4. SOCIAL SECURITY NUMBER: 204-03-1015
5. SEX: 1 ☐ MALE 2 ☒ FEMALE
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 07/30/18
8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): 550 MAIN ST.
9b. CITY, TOWN OR LOCATION OF DEATH: NEW WINDSOR
9c. COUNTY OF DEATH: CARROLL

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: CARROLL
10c. CITY, TOWN OR LOCATION: NEW WINDSOR
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 550 MAIN ST.
10f. ZIP CODE: 21776
10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed W 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: YES W W II
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: NO
14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5 +): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): VOLUNTEER
16b. KIND OF BUSINESS/INDUSTRY: BRETHREN SERVICE CENTER B.V.S.

17. FATHER'S NAME (First, Middle, Last): CHESTER W. FRY
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY ELLEN FARNER

19a. INFORMANT'S NAME (Type/Print): EARL E. BURRIS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 667 GLORIA PLACE STAUNTON VA 24401

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BURIAL
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GETTYSBURG NAT'L. CEMETERY
20c. LOCATION — City or Town, State: GETTYSBURG, PA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Catherine O. Hartzler
22. NAME AND ADDRESS OF FACILITY: D. D. HARTZLER & SONS NEW WINDSOR, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Myocardial Infarction — Minutes
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CORONARY heart disease — Years.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus Type I
Hypothyroidism.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: J. H. Caricofe MD
29c. LICENSE NUMBER: D906
29d. DATE SIGNED (Month, Day, Year): ▶ 8/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. H. CARICOFE M.D. 104 N. MAIN ST. Union Bridge, MD 21791
31. DATE FILED (Month, Day, Year): AUG 28 89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24868
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached [illegible] the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Norville E. Baker			2. DATE OF DEATH Month: 8 Day: 11 Year: 89	3. TIME OF DEATH: 0725 M
4. SOCIAL SECURITY NUMBER: 212-09-8595	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 8-23-1913	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): CARROLL COUNTY GEN. HOSP.		9b. CITY, TOWN OR LOCATION OF DEATH: WESTMINSTER, MD.		9c. COUNTY OF DEATH: CARROLL
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: CARROLL	10c. CITY, TOWN OR LOCATION: Hampstead		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 822 Houcksville Rd		10f. ZIP CODE: 21074		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Foreman		16b. KIND OF BUSINESS/INDUSTRY: Koppers Company
17. FATHER'S NAME (First, Middle, Last): Harry Baker			18. MOTHER'S NAME (First, Middle, Maiden Surname): Mamie E. Reese	
19a. INFORMANT'S NAME (Type/Print): Mrs. Helen B. Baker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 822 Houcksville Rd., Hampstead, Md. 21074		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Wesley Cemetery		20c. LOCATION — City or Town, State: Hampstead, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jerry A. Eline		22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home, 934 S. Main St. Hampstead, Md. 21074		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIORESPIRATORY ARREST

DUE TO (OR AS A CONSEQUENCE OF): N/A

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HVD

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Marcella MD.	018099	▶ 8-11-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MANUEL J. SEVILLA 61 WAKELEY RD. WESTMINSTER, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 15 '89	Julia Davidson-Randall 21157

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24869
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PHYLLIS D BUHRMAN			2. DATE OF DEATH (Month, Day, Year): August 21, 89	3. TIME OF DEATH: 12 05 P M
4. SOCIAL SECURITY NUMBER: 213-10-1730	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9-18-1910	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Westminster Nursing & Conv. Ctr.		9b. CITY, TOWN OR LOCATION OF DEATH: Westminster	9c. COUNTY OF DEATH: Carroll	
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Middleburg	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO	
10e. STREET AND NUMBER: 5800 Middleburg Road		10f. ZIP CODE: 21768	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Licensed Pract. Nurse	16b. KIND OF BUSINESS/INDUSTRY: Nursing	
17. FATHER'S NAME (First, Middle, Last): Alfred Reno Buhrman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lulu Hays		
19a. INFORMANT'S NAME (Type/Print): Thelma Rowe		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5800 Middleburg Rd., Middleburg, Md. 21768		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Uniontown Lutheran	20c. LOCATION — City or Town, State: Uniontown, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert K. Pritts, Sr.		22. NAME AND ADDRESS OF FACILITY: 412 Washington Road Westminster, Md. 21157		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma of the colon	11 Months.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D906	▶ 8/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): [illegible] 10 A. M. Main St. Union Bridge, MD. 21791

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 23 '89	Julia Davidson-Mandel

DHMH-18 Rev 1/89

89 24870

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BURNS Lucy E. BURNS
2. DATE OF DEATH (Month, Day, Year): Aug. 30, 1989
3. TIME OF DEATH: 7 P. M
4. SOCIAL SECURITY NUMBER: 220 26 5137
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5-22-08
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Blizzard Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Westminster
9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Carroll
10c. CITY, TOWN OR LOCATION: Sykesville
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 7421 Spout Hill Rd.
10f. ZIP CODE: 21784
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 High School — College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nursing Aide
16b. KIND OF BUSINESS/INDUSTRY: State Hospital
17. FATHER'S NAME (First, Middle, Last): William Casey
18. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie ?
19a. INFORMANT'S NAME (Type/Print): Wm Burns
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4022 Sykesville Rd. Finksburg, Md 21048
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen Memorial Gardens
20c. LOCATION — City or Town, State: Finksburg, Md. 21784
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry W. Haight
22. NAME AND ADDRESS OF FACILITY: Haight F.H. Box 195 Sykesville MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Advanced ASCVD	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. old age	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D25443
29d. DATE SIGNED (Month, Day, Year): ▶ 8.31.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 125 Bolt Blvd Westminster Md 21157
31. DATE FILED (Month, Day, Year): SEP 1 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 24871

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be detached for use as the burial permit.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUSSELL Russell LUTHER Creager CREAGER

2. DATE OF DEATH Month: Aug. Day: 09, Year: 1989

3. TIME OF DEATH: 11:15 AM

4. SOCIAL SECURITY NUMBER: 212-24-3097

5. SEX: 1 ☐ MALE 2 ☐ F

6. AGE (In yrs. last birthday): 87 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

7. DATE OF BIRTH (Month, Day, Year): 06/30/02

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): VINDOBONA NURSING HOME

9b. CITY, TOWN OR LOCATION OF DEATH: BRADDOCK HEIGHTS

9c. COUNTY OF DEATH: FREDERICK

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: FREDERICK

10c. CITY, TOWN OR LOCATION: KEYMAR

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO: NO

10e. STREET AND NUMBER: 12311 RENNER RD.

10f. ZIP CODE: 21757

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: NO

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: NO

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FARMER

16b. KIND OF BUSINESS/INDUSTRY: DAIRY

17. FATHER'S NAME (First, Middle, Last): THEODORE W. CREAGER

18. MOTHER'S NAME (First, Middle, Maiden Surname): JULIA ANNA WARFIELD

19a. INFORMANT'S NAME (Type/Print): RICHARD CREAGER

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 104 COURIER COURT TANEYTOWN MD 21787

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify): BURIAL

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHAPEL CEMETERY

20c. LOCATION — City or Town, State: NR. LIBERTYTOWN, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Catharine D. Hartzler

22. NAME AND ADDRESS OF FACILITY: D. D. HARTZLER & SONS WOODSBORO, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiorespiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Alzheimer's Disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Atherosclerotic Vessel Disease.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD

29c. LICENSE NUMBER: D35553

29d. DATE SIGNED (Month, Day, Year): 8/9/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 610 9th Ave Brunswick MD 21716

31. DATE FILED (Month, Day, Year): AUG 14 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24872
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Preston J. Crabbs
2. DATE OF DEATH: MONTH 08 DAY 15 YEAR 89
3. TIME OF DEATH: 2056 M
4. SOCIAL SECURITY NUMBER: 183-10-5288
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5-25-10
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Carroll County General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Westminster
9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Pennsylvania
10b. COUNTY: Adams
10c. CITY, TOWN OR LOCATION: Littlestown
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 205 ULRICKTOWN RD
10f. ZIP CODE: 17340
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SHOE FACTORY
16b. KIND OF BUSINESS/INDUSTRY: SHOE FACTORY
17. FATHER'S NAME (First, Middle, Last): CHARLES CRABBS
16. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE STAIR
19a. INFORMANT'S NAME (Type/Print): GENEVA CRABBS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 205 ULRICKTOWN RD LITTLESTOWN PA 17340
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST JOHN'S CEMETERY
20c. LOCATION — City or Town, State: LITTLESTOWN PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard Little Jr
22. NAME AND ADDRESS OF FACILITY: LITTLES F.H. 34 MAPLE AVE LITTLESTOWN, PA 17340

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Cardiovascular Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. complicated by Chronic Obstructive Pulmonary Disease

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO N/A

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: N/A M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO N/A
28d. DESCRIBE HOW INJURY OCCURED: N/A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Richard A. Jones
29c. LICENSE NUMBER: D05905
29d. DATE SIGNED (Month, Day, Year): ▶ 16 Aug 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard A. Jones, M.D. Carroll County General Hospital Westminster, Md. 21157
31. DATE FILED (Month, Day, Year): 8/16/89 AUG 21 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 24873

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. Page 4 is the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JANE L. GETTLE			2. DATE OF DEATH (Month, Day, Year): 8 9 1989	3. TIME OF DEATH: 1303 M
4. SOCIAL SECURITY NUMBER: 197-22-0960	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 60 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 10-28-1928	8. BIRTHPLACE (State or Foreign Country): Pa.

9a. FACILITY NAME (If not institution, give street and number): Carroll County Gen'l Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Westminster	9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Hampstead	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3616 Hampstead-Mexico Road		10f. ZIP CODE: 21074	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Assembly	16b. KIND OF BUSINESS/INDUSTRY: Black & Decker	
17. FATHER'S NAME (First, Middle, Last): Roy A. Forry		18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Black	
19a. INFORMANT'S NAME (Type/Print): Mr. Eugene M. Gettle	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3616 Hampstead-Mexico Road, Hampstead, Md. 21074		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen Mem. Gardens	20c. LOCATION — City or Town, State: Finksburg, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steven W. Eline	22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home 934 S. Main Street, Hampstead, Md. 21074		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ventricular fibrillation	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D05950	29d. DATE SIGNED (Month, Day, Year): ▶ 7 Jul 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard A. Jones, M.D. Carroll County General Hospital, Westminster, MD 21157

31. DATE FILED (Month, Day, Year): AUG 15 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24874

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use ... permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): TREVA E. HOFFMAN
2. DATE OF DEATH (Month, Day, Year): 08 13 1989
3. TIME OF DEATH: 4:43 PM
4. SOCIAL SECURITY NUMBER: 215 14 2138
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 09-20-1902
8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): CARROLL CO. GENERAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: WESTMINSTER
9c. COUNTY OF DEATH: CARROLL

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: CARROLL
10c. CITY, TOWN OR LOCATION: MANCHESTER
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2971 PARK AVE
10f. ZIP CODE: 21102
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY: HOME MAKING
17. FATHER'S NAME (First, Middle, Last): HENRY NELSON ZUMBRUN
18. MOTHER'S NAME (First, Middle, Maiden Surname): IDA E.L. RHODES
19a. INFORMANT'S NAME (Type/Print): HENRY L. HOFFMAN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4606 LYNNCREST DR., HAMPSTEAD MD. 21074
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OLD MANCHESTER CEM.
20c. LOCATION — City or Town, State: MANCHESTER, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. Larry Hastings
22. NAME AND ADDRESS OF FACILITY: 3296 CHARMIL DR., MANCHESTER, MD 21102

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIOGENIC SHOCK	HOURS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ACUTE MYOCARDIAL INFARCTION	"
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. ATHEROSCLEROTIC CORONARY HEART DISEASE	YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: METASTATIC COLON CARCINOMA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Vincent J. Fiocco Jr MD
29c. LICENSE NUMBER: D01663
29d. DATE SIGNED (Month, Day, Year): ▶ 8/13/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): VINCENT J. FIOCCO JR MD 6 ANCHOR ST WESTMINSTER, MD 21157
31. DATE FILED (Month, Day, Year): AUG 15 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24875

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARKWOOD Staley HEFFNER			2. DATE OF DEATH (Month / Day / Year): 8 / 11 / 89	3. TIME OF DEATH: 1740 M
4. SOCIAL SECURITY NUMBER: 215-03-3534	5. SEX: 1 X M 2 ☐ F	7. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12 7 14	6. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Carroll County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Westminster		9c. COUNTY OF DEATH: Carroll
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2026 Frizzellburg Road		10f. ZIP CODE: 21157		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mail Carrier	16b. KIND OF BUSINESS/INDUSTRY: Post Office		
17. FATHER'S NAME (First, Middle, Last): Staley Grover Heffner		18. MOTHER'S NAME (First, Middle, Maiden Surname): Vernie Alice Grossnickle		
19a. INFORMANT'S NAME (Type/Print): Mae E. Heffner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2026 Frizzellburg Road, Westminster, MD 21157		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baust Church Cemetery		20c. LOCATION — City or Town, State: Tyrone, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert A. Myers		22. NAME AND ADDRESS OF FACILITY: Myers Funeral Home 91 Willis Street, Westminster, MD 21157		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC Lung CA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CAD

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Manuel J. Sevilla MD	29c. LICENSE NUMBER: D18099	29d. DATE SIGNED (Month, Day, Year) ▶ 8-12-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MANUEL J. SEVILLA 611 NURSERY Rd. WESTMINSTER, Md		
31. DATE FILED (Month, Day, Year): AUG 14 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24876
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
David	Tracey	Hoover	8-19-89	4:40AM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
216-02-1358	1 ☒ M 2 ☐ F	17 YRS.			2-7-72	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
4515 Oakleigh Drive	Manchester	Carroll County

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Carroll	Manchester	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4515 Oakleigh Drive	21102	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
0-10		Landscaping	

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
David H. Hoover	Barbara Davidson

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Barbara Leppo	4515 Oakleigh Drive, Manchester, Md. 21102

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Greenmount Cemetery	Hampstead, Md. 21074

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Steven W. Eline	Eline Funeral Home, 934 S. Main St. Hampstead, Maryland 21074

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Contact Gunshot wound of head	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
☒ YES 2 ☐ NO	☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	8-19-89	3:17AM	1 ☐ YES ☒ NO	Self inflicted

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
home	4515 Oakleigh Dr.,Manchester, Carroll County, Maryland

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	OCME	▶ 8-19-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
James Kaplan,M.D.	111 Penn Street,Baltimore,MD 21201	VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 22 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24877
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ella Louise Joy
2. DATE OF DEATH (Month, Day, Year): 8-31-89
3. TIME OF DEATH: 1606 M
4. SOCIAL SECURITY NUMBER: 218 46 1773
5. SEX: 1 ☐ M 2 ☒ F
6. BIRTHPLACE (State or Foreign Country): Maryland
7. DATE OF BIRTH (Month, Day, Year): 12/9/11
8. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
9a. FACILITY NAME (If not institution, give street and number): Carroll County General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Westminster Md
9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Carroll
10c. CITY, TOWN OR LOCATION: Westminster
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 30 Locust St A1608
10f. ZIP CODE: 21157
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— H yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Domestic
17. FATHER'S NAME (First, Middle, Last): Augustus T. Kiefer
18. MOTHER'S NAME (First, Middle, Maiden Surname): Maggie Belle Henshaw
19a. INFORMANT'S NAME (Type/Print): Betty J. Bowman
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4065 Bark Hill Road, Union Bridge, MD 21791
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen Memorial Gardens
20c. LOCATION — City or Town, State: Finksburg, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert A. Myers
22. NAME AND ADDRESS OF FACILITY: Myers Funeral Home, 91 Willis Street, Westminster, MD 21157

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Myocardial infarction — DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Chitrachedu Nagaraja
29c. LICENSE NUMBER: D18200
29d. DATE SIGNED (Month, Day, Year): ▶ 8-31-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHITRACHEDU NAGARAJA 700 Apodeca Rd, Westminster MD 21157
31. DATE FILED (Month, Day, Year): SEP 1 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24878

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending ... permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the ... permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mildred E. Moxley			2. DATE OF DEATH (Month, Day, Year): 8 13 89	3. TIME OF DEATH: 0540 A M
4. SOCIAL SECURITY NUMBER: 168-28-1954	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3/29/1911	8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): Carroll County General Hosp.		9b. CITY, TOWN OR LOCATION OF DEATH: Westminster Md	9c. COUNTY OF DEATH: Carroll	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 82 W Green ST	10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY?: U.S.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: W

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Registered Nurse	16b. KIND OF BUSINESS/INDUSTRY: Nursing

17. FATHER'S NAME (First, Middle, Last): Charles Elliott	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Blower
19a. INFORMANT'S NAME (Type/Print): Joe Fowler	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 82 West Green St., Westminster, MD 21157

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westminster Cemetery	20c. LOCATION — City or Town, State: Westminster, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert K. Pritts, Sr.	22. NAME AND ADDRESS OF FACILITY: Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory failure	hours
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Metastatic lung CA	yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dehydration

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: D. H. Rocha	29c. LICENSE NUMBER: D36116	29d. DATE SIGNED (Month, Day, Year) ▶ 8-13-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Domingo Rocha		
31. DATE FILED (Month, Day, Year): AUG 14 '89	32. REGISTRAR'S SIGNATURE: Jane Davidson-Randall	

DHMH-18 Rev 1/89

89 24879

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/removal permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Roger MANN			2. DATE OF DEATH: MONTH 08 DAY 11 YEAR 89	3. TIME OF DEATH: 6 30 p M
4. SOCIAL SECURITY NUMBER: 218-24-2060	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 59 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5-4-30	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 2521 Ebbvale Road		9b. CITY, TOWN OR LOCATION OF DEATH: Manchester		9c. COUNTY OF DEATH: Carroll
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Manchester, Maryland		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2521 Ebbvale Road		10f. ZIP CODE: 21102		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+):		16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic		16b. KIND OF BUSINESS/INDUSTRY: Truck Bodies
17. FATHER'S NAME (First, Middle, Last): Roy Mann			18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Myerly	
19a. INFORMANT'S NAME (Type/Print): Mrs. Iva Mann		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2521 Ebbvale Road, Manchester, Md. 21102		
20a. METNOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Wesley Cemetery		20c. LOCATION — City or Town, State: Hampstead, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steven W. Eline		22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home, 934 S. Main St. Hampstead, Md. 21074		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory srrest, shock, or heart feilure. List Dnly one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel diseese or condition resulting in death) →	a. Hepatocellular Carcinoma	1 year
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if eny, leeding to immediete ceuse. Enter UNDERLYING CAUSE (Diseese or injury that initiated events resulting in deeth) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☑ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEOICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☑ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined			1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Norman Goldstein, M.D.	D26385	▶ 8/12/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Norman Goldstein 218 Washington Heights Medical Ctr. Westminster, MD 21157

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 15 '89	Julia Davidson-Randall

DHMH-18 Rev 1/89

ITEM:28d per ME G-665
7-18-90 cm

89 24880

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Nancy Irene Mapstone		2. DATE OF DEATH (Month, Day, Year): 8-18-89	3. TIME OF DEATH: 6:45PM M
4. SOCIAL SECURITY NUMBER: 113-46-8535	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 37 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Apr. 21, 1952
8. BIRTHPLACE (State or Foreign Country): New York			
9a. FACILITY NAME (If not institution, give street and number): 4233 Valley Vista Court	9b. CITY, TOWN OR LOCATION OF DEATH: Manchester	9c. COUNTY OF DEATH: Carroll County	
RESIDENCE OF DECEDENT			
10a. STATE: Md.	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Manchester	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4233 Valley Vista Court	10f. ZIP CODE: 21102	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk	16b. KIND OF BUSINESS/INDUSTRY: Furniture Store	
17. FATHER'S NAME (First, Middle, Last): Adolph Kralisz	18. MOTHER'S NAME (First, Middle, Maiden Surname): Amelia Voitcowski		
19a. INFORMANT'S NAME (Type/Print): William F. Mapstone, Jr.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4233 Valley Vista Court, Manchester, Md. 21102		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory	20c. LOCATION — City or Town, State: Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: H.J. Eckhardt	22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Carbon monoxide intoxication
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-18-89	28b. TIME OF INJURY: 11:00AM
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: INHALED FUMES FROM CHARCOAL GRILL (USED INDOORS) Inhaled fumes from auto	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 4233 Valley Vista Ct., Manchester, Carroll County, Maryland	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 8-19-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan, M.D. 111 Penn Street, Baltimore, MD 21201		VC
31. DATE FILED (Month, Day, Year): AUG 22 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 24881

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RACHAEL Belle MARTIN			2. DATE OF DEATH MONTH: Aug DAY: 21 YEAR: 89		3. TIME OF DEATH: 2:30P M
4. SOCIAL SECURITY NUMBER: 215-36-8246	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 91 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 3-6-1898	8. BIRTHPLACE (State or Foreign Country): Baltimore City Md
9a. FACILITY NAME (If not institution, give street and number): 5107 Dusty LANE		9b. CITY, TOWN OR LOCATION OF DEATH: Linchoro Md			9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Linchoro, Md.	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 5107 Dusty LANE		10f. ZIP CODE: 21088	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 8th grade College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: —

17. FATHER'S NAME (First, Middle, Last): Walter M CART	18. MOTHER'S NAME (First, Middle, Maiden Surname): M Norma Gardner
19a. INFORMANT'S NAME (Type/Print): Mrs Nellie HANN	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5107 Dusty Lane Linchoro Md 21088

20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Abraham's Cemetery	20c. LOCATION — City or Town, State: Hampstead, Md. 21074

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steven W. Eline	22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home, 934 S. Main St. Hampstead, Md. 21074

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Heart Disease	6 Mos
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia
generalized Arteriosclerosis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: WH Foard MD	29c. LICENSE NUMBER: D02386 Md	29d. DATE SIGNED (Month, Day, Year): ▶ Aug 21-1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WH Foard MD 3223 Main St Box 50 Manchester Md 21102		
31. DATE FILED (Month, Day, Year): AUG 22 89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Kindall	

DHMH-16 Rev 1/89

89 24882

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dolores M. Magness		2. DATE OF DEATH (Month, Day, Year): Aug. 29, '89	3. TIME OF DEATH: 11:30 AM M
4. SOCIAL SECURITY NUMBER: 218-34-0154	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (in yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12/27/12
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): CARROLL Lutheran Village	9b. CITY, TOWN OR LOCATION OF DEATH: Westminster	9c. COUNTY OF DEATH: Carroll	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Hampstead	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 650 Marpeze Drive	10f. ZIP CODE: 21074	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): UNKNOWN	College (1-4 or 5+): 2 yrs. college UNKNOWN	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: —
17. FATHER'S NAME (First, Middle, Last): Dennis MacAleer		18. MOTHER'S NAME (First, Middle, Maiden Surname): Marye Shaffer	
19a. INFORMANT'S NAME (Type/Print): Audrey Byrd RN	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~296~~ 200 St. Luke Circle Westminster 21157		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery	20c. LOCATION — City or Town, State: Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steven W. Eline	22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home, 934 S. Main St. Hampstead, Md. 21074		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. Urinary Tract infection with Sepsis	1 wk.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bilateral bronchopneumonia
Hypertension
Multiple strokes

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J.A. Caricofe MD	29c. LICENSE NUMBER: D906	29d. DATE SIGNED (Month, Day, Year) ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J.H. CARICOFE MD. 104 N. Main St. Union Bridge, Md. 21791		
31. DATE FILED (Month, Day, Year): SEP 1 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24883

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2 & should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LUZ MARIA HERNANDEZ NUNEZ
2. DATE OF DEATH (Month, Day, Year): 8 28 1989
3. TIME OF DEATH: 2105 M
4. SOCIAL SECURITY NUMBER: 134-32-6992
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 47 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): MARCH 18, 1942
8. BIRTHPLACE (State or Foreign Country): PUERTO RICO
9a. FACILITY NAME (If not institution, give street and number): 2 UNION ST WESTMINSTER, Md
9b. CITY, TOWN OR LOCATION OF DEATH: WESTMINSTER
9c. COUNTY OF DEATH: CARROLL

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: CARROLL
10c. CITY, TOWN OR LOCATION: WESTMINSTER
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2 UNION ST WESTMINSTER MD.
10f. ZIP CODE: 21157
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☒ YES 2 ☐ NO Specify: PUETO RICAN
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSE CLEANING
16b. KIND OF BUSINESS/INDUSTRY: DOMESTIC
17. FATHER'S NAME (First, Middle, Last): JUAN HERNANDEZ
18. MOTHER'S NAME (First, Middle, Maiden Surname): GLORIA HERNADEZ
19a. INFORMANT'S NAME (Type/Print): LENOR ANN NUNEZ
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2202 WOODSIDE LANE, SACREMENTO California 95825
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CARROLL CREMATORY
20c. LOCATION — City or Town, State: HAMPSTEAD, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert A Myers
22. NAME AND ADDRESS OF FACILITY: 91 WILLS ST. 21157 MYERS FUNERAL HOME

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CARCINOMA OF RECTUM-METATASIS	8 MONTHS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	AUTO IMMUNE DEFICIENCY SYNDROME	4 YEARS
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. LICENSE NUMBER: DH 596
29d. DATE SIGNED (Month, Day, Year): ▶ 8-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DANIEL I. WELLIVER WESTMINSTER MARYLAND
31. DATE FILED (Month, Day, Year): AUG 30 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24884
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Marshall Nicholson				2. DATE OF DEATH (Month, Day, Year): 8 27 1989	3. TIME OF DEATH: 6:30 PM
4. SOCIAL SECURITY NUMBER: 071-16-7760	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 4-25-1910	8. BIRTHPLACE (State or Foreign Country): Buffalo, N.Y.
9a. FACILITY NAME (If not institution, give street and number): Apt 37 Timber Ridge Drive			9b. CITY, TOWN OR LOCATION OF DEATH: Westminster, Md.		9c. COUNTY OF DEATH: Carroll
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Carroll		10c. CITY, TOWN OR LOCATION: Westminster, Maryland		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: Apt 37, Timber Ridge Drive			10f. ZIP CODE: 21157		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO; IF YES, GIVE WAR OR DATES: WWII		13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Painting		16b. KIND OF BUSINESS/INDUSTRY: Painting Contractor
17. FATHER'S NAME (First, Middle, Last): James Nicholson				18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Devoicnes	
19a. INFORMANT'S NAME (Type/Print): Lois Hayden			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 605 Bentley Ct. Columbia, S.C. 29210		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Cremation Services		20c. LOCATION — City or Town, State: Hampstead, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas D. Fletcher			22. NAME AND ADDRESS OF FACILITY: Thomas D. Fletcher & Son Funeral Home 254 East Main St. Westminster, Md. 21157		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC RECTAL CA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 5 ☐ Pending investigation 2 ☐ Accident 3 ☐ Suicide 8 ☐ Could not be determined 4 ☐ Homicide		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D18097	▶ 8-28-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] 611 Nursery Rd. Westminster, Md. 21157

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 28 89	Julia Davidson-Kindell

DHMH-18 Rev 1/89

89 24885

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital for tracking physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached. You must get the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HATTIE R ROBERTS			2. DATE OF DEATH (Month, Day, Year): 8 20 89	3. TIME OF DEATH: 1910 M
4. SOCIAL SECURITY NUMBER: 220-12-6980	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-18-22	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): CARROLL County General Hosp.		9b. CITY, TOWN OR LOCATION OF DEATH: Westminster		9c. COUNTY OF DEATH: Carroll
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 165 W. Main, Rear		10f. ZIP CODE: 21157		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): machine operator		16b. KIND OF BUSINESS/INDUSTRY: Black & Decker
17. FATHER'S NAME (First, Middle, Last): James Rutherford		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Bruce		
19a. INFORMANT'S NAME (Type/Print): Leonard Roberts		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 165 W. Main St., Rear, Westminster, MD 21157		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. James		20c. LOCATION — City or Town, State: New Windsor, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert K. Pritts Sr/wl — Robert K. Pritts, Sr.		22. NAME AND ADDRESS OF FACILITY: 412 Washington Rd. Westminster, MD. 21157		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory failure	6 hrs.
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Cor Pulmonale	yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Chronic Obstructive Pulmonary Disease	yrs
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: D Rocha MD	29c. LICENSE NUMBER: D36-116	29d. DATE SIGNED (Month, Day, Year): ▶ 8-20-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): AUG 23 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24886 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DORIS L STARNER			2. DATE OF DEATH (Month, Day, Year): 8 26 89	3. TIME OF DEATH: 0838 M
4. SOCIAL SECURITY NUMBER: 216228526	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 62 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5/15/27	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): CARROLL CO GEN NOSP	9b. CITY, TOWN OR LOCATION OF DEATH: WESTMINSTER MD	9c. COUNTY OF DEATH: CARROLL		

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: CARROLL	10c. CITY, TOWN OR LOCATION: WESTMINISTER	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 47 PENNSYLVANIA AVE	10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamtress	16b. KIND OF BUSINESS/INDUSTRY: Grief Sewing Factory	
17. FATHER'S NAME (First, Middle, Last): Clarence Ricketts	18. MOTHER'S NAME (First, Middle, Maiden Surname): Myrle Myers		
19a. INFORMANT'S NAME (Type/Print): Richard L. Starner	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 47 Pennsylvania Ave, Westminster, Md. 21157		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Kriders Cemetery	20c. LOCATION — City or Town, State: Westminster, Md. 21157	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Nancy K. Fletcher	22. NAME AND ADDRESS OF FACILITY: Thomas D. Fletcher & Son Funeral Home 254 East Main Street Westminster, Md. 21157		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIAC ARREST	Instant
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic carcinoma
Diabetes Mellitus
Systemic Hypertension

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 6 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Chitrachedu Nagaraja	29c. LICENSE NUMBER: D18200	29d. DATE SIGNED (Month, Day, Year): ▶ 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHITRACHEDU NAGARAJA MD - 700 Apodeka Westminster MD 21157		
31. DATE FILED (Month, Day, Year): AUG 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24887

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Scott / Dwike / Smith			2. DATE OF DEATH (Month, Day, Year): 8-27-89	3. TIME OF DEATH: 11:50AM M
4. SOCIAL SECURITY NUMBER: 215-94-9614	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 18 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4 25 71	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 1325 E. Boerner Road		9b. CITY, TOWN OR LOCATION OF DEATH: Westminster		9c. COUNTY OF DEATH: Carroll County

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1325 Boerner Rd.		10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): meat cutter	16b. KIND OF BUSINESS/INDUSTRY: meat packing co.
17. FATHER'S NAME (First, Middle, Last): Raymond Elwood Wike		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ann Elizabeth Smith	
19a. INFORMANT'S NAME (Type/Print): Ann E. Smith		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 235 E. Baltimore St. Taneytown, MD 21787	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Blue Ridge Cemetery	20c. LOCATION — City or Town, State: Thurmont, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Catharine O. Hartzler		22. NAME AND ADDRESS OF FACILITY: D.D. Hartzler & Sons, Woodsboro, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Contact intraoral shotgun wound	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? XXX 1 YES 2 [ ] NO PARTIAL HEAD ONLY	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home XXX Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 XXX Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-27-89	28b. TIME OF INJURY: 9:30AM	28c. INJURY AT WORK? 1 [ ] YES XXX NO
	28d. DESCRIBE HOW INJURY OCCURED: Self inflicted		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1325 E. Boerner Dr. Westminster, Carroll County, Maryland	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin, M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 VC		
31. DATE FILED (Month, Day, Year): AUG 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

Item 1 corrected per F.H. 9/12/89 reb

89 24888

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1,2,3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) MARGARET G. STEVENSON			2. DATE OF DEATH MONTH 8 DAY 31 YEAR 89	3. TIME OF DEATH 0430 M
4. SOCIAL SECURITY NUMBER 214-10-1333	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) 07-26-17
6. BIRTHPLACE (State or Foreign Country) MD				
9a. FACILITY NAME (If not institution, give street and number) Carroll County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Westminster MD		9c. COUNTY OF DEATH Carroll
RESIDENCE OF DECEDENT				
10a. STATE MD	10b. COUNTY Carroll	10c. CITY, TOWN OR LOCATION Westminster		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER 1234 WASHINGTON RD.		10f. ZIP CODE 21157		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 11 College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY HEALTH
17. FATHER'S NAME (First, Middle, Last) SAMUEL JESSE GLADHILL		18. MOTHER'S NAME (First, Middle, Maiden Surname) ADDIE SHEPLEY		
19a. INFORMANT'S NAME (Type/Print) MARTIN J. SMITH		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 143 MAIN ST., REISTERSTOWN, MD. 21136		
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) EVERGREEN MEM. GARDENS		20c. LOCATION — City or Town, State 21048 FINKSBURG, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ H.J. Eckhardt		22. NAME AND ADDRESS OF FACILITY ECKHARDT FUNERAL CHAPEL OWINGS MILLS, MD 21117		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Gram Positive Septicaemia
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Urosepsis
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe Anemia & Thrombocytosis
Multiple sclerosis with quadriplegia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Hafeez A. Syed M.D.	D25002	▶ 8/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
HAFEEZ A SYED, 20 CROSSROADS DRIVE, OWINGS MILLS MD 21133

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 22 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 24889

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HENRY G SAUTTER			2. DATE OF DEATH (Month, Day, Year): AUG 21 89	3. TIME OF DEATH: 3:50 P M
4. SOCIAL SECURITY NUMBER: 213-26-3834	5. SEX: 1 ☑ M 2 ☐ F	5. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 01-05-29	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 5127 Braddock Road		9b. CITY, TOWN OR LOCATION OF DEATH: Woodbine		9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Carroll County	10c. CITY, TOWN OR LOCATION: Woodbine	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5127 Braddock Road	10f. ZIP CODE: 21797		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Agent	16b. KIND OF BUSINESS/INDUSTRY: Internal Revenue Service	
17. FATHER'S NAME (First, Middle, Last): Henry Godfrey Sautter		18. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie E. Blottenberger	
19a. INFORMANT'S NAME (Type/Print): Aline M. Sautter		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5127 Braddock Rd. Woodbine, MD 21797	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery	20c. LOCATION — City or Town, State: Glen Burnie, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian L. Haight		22. NAME AND ADDRESS OF FACILITY: HAIGHT FUNERAL HOME (P.O. BOX 195) SYKESVILLE, MD 21784 (301)-795-1400	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MULTIPLE MYELOMA	5 YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Arthur L Rudo, MD	29c. LICENSE NUMBER: D21155	29d. DATE SIGNED (Month, Day, Year): ▶ 8/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ARTHUR L. RUDO, MD 524-B BALTIMORE BLVD WESTMINSTER, MD

31. DATE FILED (Month, Day, Year): AUG 23 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 24890

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NELLIE L STRAKES			2. DATE OF DEATH: MONTH 8 DAY 28 YEAR 89	3. TIME OF DEATH: 2222 PM
4. SOCIAL SECURITY NUMBER: 212-20-7029	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 06-22-1920	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): CARROLL CO. GENERAL HOSP.		9b. CITY, TOWN OR LOCATION OF DEATH: WESTMINSTER		9c. COUNTY OF DEATH: CARROLL
RESIDENCE OF DECEDENT				
10a. STATE: Md	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: UPPERCO		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 15026 HANOVER PIKE		10f. ZIP CODE: 21155		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC		16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): HARILAND			18. MOTHER'S NAME (First, Middle, Maiden Surname):	
19a. INFORMANT'S NAME (Type/Print): ROBERT L. STRAKES		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15026 HANOVER PIKE, UPPERCO, MD. 21155		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METRO CREMATORY INC		20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. Larry Nuttlemyer		22. NAME AND ADDRESS OF FACILITY: ECKHARDT FUNERAL CHAPEL OWINGS MILLS, MD 21117		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF): Bilateral Basilar Pneumonia

c. DUE TO (OR AS A CONSEQUENCE OF): Intracerebral Hemorrhage

d. DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination, and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: 025950 | 29d. DATE SIGNED (Month, Day, Year): ▶ 29 Aug 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD JONES, CARROLL COUNTY HOSPITAL, WESTMINSTER

31. DATE FILED (Month, Day, Year): AUG 31 89 | 32. REGISTRAR: [signature]

DHMH-18 Rev 1/89

89 24891

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) ~~Dorothy~~ Bessie W Sherman		2. DATE OF DEATH MONTH DAY YEAR 8-18-89	3. TIME OF DEATH 1300 M
4. SOCIAL SECURITY NUMBER 213-01-3153	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 85 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 9-27-1903
8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) Carroll County Gen Hospital	9b. CITY, TOWN OR LOCATION OF DEATH Westminster	9c. COUNTY OF DEATH Carroll	

RESIDENCE OF DECEDENT

10a. STATE MD	10b. COUNTY Carroll	10c. CITY, TOWN OR LOCATION Westminster	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER 1808 Old Taneytown Road		10f. ZIP CODE 21157	10g. CITIZEN OF WHAT COUNTRY? U.S.

11. MARITAL STATUS 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress	16b. KIND OF BUSINESS/INDUSTRY Westminster Knit
17. FATHER'S NAME (First, Middle, Last) James Welty		16. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Shorb	
19a. INFORMANT'S NAME (Type/Print) William T. Sherman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1808 Old Taneytown Rd., Westminster, MD	
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Keysville Cemetery	20c. LOCATION — City or Town, State Detour, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Robert K. Pritts, Sr.		22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ventricular Standstill	Instant
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute Myocardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Christachedu Nagamma	29c. LICENSE NUMBER D18200	29d. DATE SIGNED (Month, Day, Year) ▶ 8/18/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHITRACHEDU NAGAMMA MD 700A Poole Rd Westminster MD 21157

31. DATE FILED (Month, Day, Year) AUG 21 '89	32. REGISTRAR'S SIGNATURE Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24892

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HUGH THOMAS TAGGART			2. DATE OF DEATH (Month, Day, Year): Aug. 20, 1989	3. TIME OF DEATH: 12:10 PM
4. SOCIAL SECURITY NUMBER: 215-20-3425	5. SEX: 1 ☐ MALE	6. AGE (In yrs. last birthday): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 06/03/27
8. BIRTHPLACE (State or Foreign Country): MARYLAND				
9a. FACILITY NAME (If not institution, give street and number): CARROLL COUNTY GENERAL HOSP.	9b. CITY, TOWN OR LOCATION OF DEATH: WESTMINSTER	9c. COUNTY OF DEATH: CARROLL		
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: CARROLL	10c. CITY, TOWN OR LOCATION: NEW WINDSOR	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO: NO	
10e. STREET AND NUMBER: 1626 OLD NEW WINDSOR RD.	10f. ZIP CODE: 21776	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced: M	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO: YES. IF YES, GIVE WAR OR DATES: W W II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO. Specify: NO	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PURCHASER	16b. KIND OF BUSINESS/INDUSTRY: INDUST.PUMP		
17. FATHER'S NAME (First, Middle, Last): PAUL D. TAGGART, SR.	18. MOTHER'S NAME (First, Middle, Maiden Surname): CLARE REGINA KELLY			
19a. INFORMANT'S NAME (Type/Print): RACHAEL G. TAGGART	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1626 OLD NEW WINDSORNEW WINDSOR MD 21776			
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BURIAL	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PIPE CREEK CEMETERY	20c. LOCATION — City or Town, State: NR.NEW WINDSOR, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Catharine D. Hartzler	22. NAME AND ADDRESS OF FACILITY: D. D. HARTZLER & SONS NEW WINDSOR, MD			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac thrombosis	5 min
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	Coronary disease	5 yrs
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO: X	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO: X	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA: X OTHER: 4 ☐ Nursing Home 6 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural: X 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: X To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John M. Leigh	29c. LICENSE NUMBER: D20330	29d. DATE SIGNED (Month, Day, Year) ▶ 8/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN M. LEIGH 104 N MAIN ST. UNION BRIDGE, MD 21791

31. DATE FILED (Month, Day, Year): AUG 22 89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-24893

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LILLIAN E. WELKER (Welker, Edna Lillian)

2. DATE OF DEATH (Month, Day, Year): AUG. 23, 1989

3. TIME OF DEATH: 5:13 PM

4. SOCIAL SECURITY NUMBER: 214-22-5976 (214-22-3976)

5. SEX: 1 ☐ MALE 2 ☒ FEMALE

6. AGE (In yrs. last birthday): 79 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 10/11/1909

8. BIRTHPLACE (State or Foreign Country): CZECHOSLAVAKIA

9a. FACILITY NAME (If not institution, give street and number): CARROLL COUNTY GENERAL HOSP (Carroll County General Hosp.)

9b. CITY, TOWN OR LOCATION OF DEATH: WESTMINSTER (Westminster md)

9c. COUNTY OF DEATH: CARROLL (Carroll)

RESIDENCE OF DECEDENT

10a. STATE: MD (Md)

10b. COUNTY: CARROLL (Carroll)

10c. CITY, TOWN OR LOCATION: UNION BRIDGE (Union Bridge)

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO (NO)

10e. STREET AND NUMBER: 1494 MCKINSTRY MILL RD. (1494 McKinstry Mil)

10f. ZIP CODE: 21791

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced (W)

12a. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO
IF YES, GIVE WAR OR DATES: NO

13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☐ NO Specify: NO

14. RACE — American Indian, Black, White, etc.
Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 11
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CAFETERIA WORKER

16b. KIND OF BUSINESS/INDUSTRY: PUB. SCHOOL

17. FATNER'S NAME (First, Middle, Last): GUSTAV KOUCOUREK

18. MOTNER'S NAME (First, Middle, Maiden Surname): SOPHIA KOEHLER

19a. INFORMANT'S NAME (Type/Print): WAYNE B. WELKER

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1494 MCKINSTRY MILL UNION BRIDGE MD 21791

20a. METNOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BURIAL

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. ZION CEMETERY

20c. LOCATION — City or Town, State: QUINCY, PA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Catharine O. Hartzler

22. NAME AND ADDRESS OF FACILITY: D. D. HARTZLER & SONS
UNION BRIDGE, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complicetions that caused the death. Do not enter the mode of dying, such ea cerdiac or reapiratory arreat, shock, or heart feilure. Liet only one cause on each lina.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ATHEROSCLEROTIC HEART DISEASE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATN: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYINO PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John S. Harshey, M.D.

29c. LICENSE NUMBER: DO 4934

29d. DATE SIGNED (Month, Day, Year): 8/23/89

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print): JOHN S. HARSHEY, M.D. 8 ANCHOR ST. WESTMINSTER, MD. 21157

31. DATE FILED (Month, Day, Year): AUG 25 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24894

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jessie Belle Young

2. DATE OF DEATH (Month, Day, Year): 8 30 1989

3. TIME OF DEATH: 12:02 P. M

4. SOCIAL SECURITY NUMBER: 219-42-5166

5. SEX: 1 ☒ M 2 ☐ F

6. AGE (In yrs. last birthday): 88 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 3-18-01

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): 118 Pennsylvania Ave

9b. CITY, TOWN OR LOCATION OF DEATH: Westminster

9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Carroll

10c. CITY, TOWN OR LOCATION: Westminster,

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 118 Pennsylvania Ave

10f. ZIP CODE: 21157

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 7th
College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): Jacob D. Starner

18. MOTHER'S NAME (First, Middle, Maiden Surname): Jessie Isabella Dayhoof

19a. INFORMANT'S NAME (Type/Print): Raymond L. Young

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 118 Pennsylvania Ave, Westminster, Md. 21157

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Kriders Cemetery

20c. LOCATION — City or Town, State: Westminster, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Nancy K. Fletcher

22. NAME AND ADDRESS OF FACILITY: Thomas D. Fletcher & Son F.H.
254 East Main Street
Westminster, Md. 21157

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Metastatic cancer to brain	2 mo
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Carcinoma of lung	4½ yr
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William O'Rourke

29c. LICENSE NUMBER: D09389

29d. DATE SIGNED (Month, Day, Year): ▶ 08/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William R. O'ROurke, M.D. 150 W. Main Street, Westminster, MD 21157

31. DATE FILED (Month, Day, Year): AUG 31 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24895
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MELVIN Sterling ZEPP				2. DATE OF DEATH: MONTH 8 DAY 26 YEAR 89	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 217-18-8633	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 6-27-21	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 912 Old Westminster Pike			9b. CITY, TOWN OR LOCATION OF DEATH: Westminster		9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 912 Old Westminster Pike		10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII - Army	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Jonas Zepp		18. MOTHER'S NAME (First, Middle, Maiden Surname): Larue Stonesifer	
19a. INFORMANT'S NAME (Type/Print): Louise Stem Zepp	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 912 Old Westminster Pike Westminster, Md. 21157		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Pleasant Valley Cemetery	20c. LOCATION — City or Town, State: Pleasant Valley Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Nancy K. Fletcher	22. NAME AND ADDRESS OF FACILITY: Thomas D. Fletcher & Son Funeral Home 254 East Main Street Westminster, Md. 21157		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ischemic myocardiopathy	1 year
DUE TO (OR AS A CONSEQUENCE OF):	b. arteriosclerotic cardiovascular disease	15 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
diabetes mellitus, type 2 (4 years)
hypertension
nephrosclerosis → 2° renal failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Park W. Espenschade	29c. LICENSE NUMBER: D01079	29d. DATE SIGNED (Month, Day, Year) ▶ 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Park W. Espenschade, Jr. M.D.

PARK W. ESPENSCHADE, JR., M.D., P.A.
419 MALCOLM DRIVE, BUILDING F
P.O. BOX 587
WESTMINSTER, MD 21157

31. DATE FILED (Month, Day, Year): AUG 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 24896

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Eva Ford Childs			2. DATE OF DEATH (Month, Day, Year): Aug 19 1989	3. TIME OF DEATH: Approx 400 AM
4. SOCIAL SECURITY NUMBER: 165-50-1627	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 94 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 10, 1895	8. BIRTHPLACE (State or Foreign Country): N.J.
9a. FACILITY NAME (If not institution, give street and number): North East Nazarene Center		9b. CITY, TOWN OR LOCATION OF DEATH: North East	9c. COUNTY OF DEATH: Cecil	

RESIDENCE OF DECEDENT

10a. STATE: Florida	10b. COUNTY: Hillsborough	10c. CITY, TOWN OR LOCATION: Plant City	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 244 Country Club Drive		10f. ZIP CODE: 33565	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ ND IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Unknown		18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown	
19a. INFORMANT'S NAME (Type/Print): Eva C. McCoy	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rte. 1 Box 196 Sweet Valley, PA 18656		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery	20c. LOCATION — City or Town, State: Collingdale, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert L. Crouch	22. NAME AND ADDRESS OF FACILITY: Crouch Funeral Home 127 S. Main St. North East, MD 21901		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary artery disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ ND	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ ND		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ ND	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 8 ☐ Residence 8 ☒ Other (Specify) Religious Camp		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Deputy Medical Examiner	29c. LICENSE NUMBER: D 17691	29d. DATE SIGNED (Month, Day, Year): ▶ Aug 19, 1989	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Juan C Gonzalez-Vitali Union Hospital Elkton MD 21921			
31. DATE FILED (Month, Day, Year): AUG 21 '89	32. REGISTRAR'S SIGNATURE: Sophie Davidson-Randall		

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the [illegible] attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be [illegible] the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24897 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Claude W. Carter
2. DATE OF DEATH (Month, Day, Year): AUGUST 20, 1989
3. TIME OF DEATH: 3:24AM M
4. SOCIAL SECURITY NUMBER: 229 14 7637
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 65 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-2-24
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Perrypoint Vet. Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Perrypoint
9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Charles
10c. CITY, TOWN OR LOCATION: Waldorf
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 130 Ell Street
10f. ZIP CODE: 20602
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWI & Korean
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th grade — College (1-4 or 5+):
15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): U S Army
16b. KIND OF BUSINESS/INDUSTRY: Govt
17. FATHER'S NAME (First, Middle, Last): WILL DAVIS
16. MOTHER'S NAME (First, Middle, Maiden Surname): MARY LONG
19a. INFORMANT'S NAME (Type/Print): Anna Carter
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 130 Ell Street, Waldorf, MD 20602
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery
20c. LOCATION — City or Town, State: Cheltenham, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: The Huntt Funeral HOme, P O Box 156, Waldorf, MD 20604

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MYOCARDIAL INFARCTION — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CHRONIC OBSTRUCTION PULMONARY DISEASE — DUE TO (OR AS A CONSEQUENCE OF):	
	c. — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): AUGUST 20, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THOMAS E. FINUCAN, JR., M.D., VAMC, PERRY POINT, MD.
31. DATE FILED (Month, Day, Year): AUG 23 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-15 Rev 1/89

89 24898

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gail D. Guinn			2. DATE OF DEATH (Month / Day / Year): 8 / 28 / 89	3. TIME OF DEATH: 10:25 P M
4. SOCIAL SECURITY NUMBER: 207-64-0486	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 17 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 9, 1972	8. BIRTHPLACE (State or Foreign Country): Lancaster, Pa.
9a. FACILITY NAME (If not institution, give street and number): 112 High Point Rd.,		9b. CITY, TOWN OR LOCATION OF DEATH: Elkton	9c. COUNTY OF DEATH: Cecil	
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: Elkton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 112 High Point Road		10f. ZIP CODE: 21921	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES: X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student	16b. KIND OF BUSINESS/INDUSTRY: none		
17. FATHER'S NAME (First, Middle, Last): W. Marvin Guinn		18. MOTHER'S NAME (First, Middle, Maiden Surname): Geraldine Pope		
19a. INFORMANT'S NAME (Type/Print): W. Marvin Guinn		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 112 High Point Road Elkton, Md. 21921		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Calvery Baptist Cemetery	20c. LOCATION — City or Town, State: Rising Sun, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward McKee		22. NAME AND ADDRESS OF FACILITY: Gee Funeral Home, 259 E. Main St., Elkton, Md. 21921		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. DO not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Undifferentiated Pelvic Carcinoma	14 mo
	OUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Henry Farkas, MD	D15314	▶ 8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Henry Farkas, MD, Northern Chesapeake Hospice, 107 Court House Square, Elkton, MD 21921

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

2

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24899
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Edward Harris		2. DATE OF DEATH (Month, Day, Year): August 15, 1989	3. TIME OF DEATH: 1:55 P M
4. SOCIAL SECURITY NUMBER: 212-16-5777	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 1-5-14
8. BIRTHPLACE (State or Foreign Country): N.C.			
9a. FACILITY NAME (If not institution, give street and number): PerryPoint V.A. Hosp	9b. CITY, TOWN OR LOCATION OF DEATH: PerryVille M.D.	9c. COUNTY OF DEATH: Cecil Co.	
RESIDENCE OF DECEDENT			
10a. STATE: M.D.	10b. COUNTY: Wicomico	10c. CITY, TOWN OR LOCATION: Fruitland	10d. INSIDE CITY LIMITS? [X] 1 YES 2 [ ] NO
10e. STREET AND NUMBER: 426 Cartwright Ave.	10f. ZIP CODE: 21825	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: X	14. RACE — American Indian, Black, White, etc. Specify: Blk.
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired	16b. KIND OF BUSINESS/INDUSTRY: Foos Service	
17. FATHER'S NAME (First, Middle, Last): U.N. K.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Alethia Harris	
19a. INFORMANT'S NAME (Type/Print): Ruth Harris	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1013 Pemberton Apt 9 Salisbury Md. 21801		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify):	20b. PLACE OF DISPOSITION (Name of cemetery, Crematory, or Other): Maryland Vetern Cemetery	20c. LOCATION — City or Town, State: Hurlock Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Russell A. Lab	22. NAME AND ADDRESS OF FACILITY: Fo[illegible] Salisbury Md. 21804	7/H P&B 1574	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Severe Chronic Obstructive Pulmonary Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. with Pneumonia

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Avelina Hernandez

29c. LICENSE NUMBER: D27573

29d. DATE SIGNED (Month, Day, Year): ▶ 8-15-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): AVELINA HERNANDEZ, M.D.

31. DATE FILED (Month, Day, Year): AUG 18 89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

5

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24900
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Walter HATFIELD					2. DATE OF DEATH (Month, Day, Year): August 18, 1989	3. TIME OF DEATH: 8:30 A M
4. SOCIAL SECURITY NUMBER: 407-22-1447	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb. 6, 1923	8. BIRTHPLACE (State or Foreign Country): Kentucky
9a. FACILITY NAME (If not institution, give street and number): Veterans Administration Medical Center			9b. CITY, TOWN OR LOCATION OF DEATH: Perry Point		9c. COUNTY OF DEATH: Cecil	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: Elkton	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 621 Delaware Avenue		10f. ZIP CODE: 21921	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: World War II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance Department	16b. KIND OF BUSINESS/INDUSTRY: Automobile Manufacturing	
17. FATHER'S NAME (First, Middle, Last): Thomas Hatfield		18. MOTHER'S NAME (First, Middle, Maiden Surname): Caroline Hatfield	
19a. INFORMANT'S NAME (Type/Print): Shirley A. Rash	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 621 Delaware Avenue Elkton, MD 21921		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) August 23, 1989	20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Gilpin Manor Memorial Park	20c. LOCATION — City or Town, State: Elkton, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ralph E. Hicks	22. NAME AND ADDRESS OF FACILITY: Hicks Home for Funerals, P.A. Bow & Stockton Streets Elkton, MD 21921		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic Obstructive Pulmonary Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
VI Jay Nellore	AV4684292NL	▶ 8/18/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): VI JAY NELLORE, M.D.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 23 '89	Gloria Davidson-Randall

ONMN-16 Rev 1/89

4 photos

89 24901

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Types 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH J. JUERGENS , Sr.		2. DATE OF DEATH (Month, Day, Year): August 22, 1989	3. TIME OF DEATH: 6:20A M
4. SOCIAL SECURITY NUMBER: 217 24 0245	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 56 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-27-33
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): VA Medical Center	9b. CITY, TOWN OR LOCATION OF DEATH: Perry Point	9c. COUNTY OF DEATH: Cecil	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: Elkton	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 106 Stockton Street	10f. ZIP CODE: 21921	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEOENT EYER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, OIVE WAR OR DATES: KOREAN WAR	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesman	16b. KIND OF BUSINESS/INDUSTRY: Auto Parts	
17. FATHER'S NAME (First, Middle, Last): Alfred P. Juergens	18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Mae Boyer		
19a. INFORMANT'S NAME (Type/Print): Richard A. Juergens	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 224 Whitehall Rd., Elkton, MD 21921		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Immaculate Conception (Old)	20c. LOCATION — City or Town, State: Elkton,.MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ralph E. Hicks	22. NAME AND ADDRESS OF FACILITY: Hicks Home for Funerals, P A Bow & Stockton Streets Elkton, Maryland 21921		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebral Vascular Accident	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Nadeem Qamar	29c. LICENSE NUMBER: D35690	29d. DATE SIGNED (Month, Day, Year): ▶ 8-22-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NADEEM QAMAR, M.D., VA Medical Center, Perry Point, MD 21902

31. DATE FILED (Month, Day, Year): AUG 23 '89	32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

DHMH-16 Rev 1/89

3 + 1 grats

89 24902

271

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWIN HARTLEY MAY			2. DATE OF DEATH: August 24 1989	3. TIME OF DEATH: 4:10AM M
4. SOCIAL SECURITY NUMBER: 218-38-3467	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 48 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3-28-41	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Perry Point VA Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Perry Point		9c. COUNTY OF DEATH: MD Cecil Co.

RESIDENCE OF DECEDENT

10e. STATE: MD	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: North East	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 660 Trinity Church Road		10f. ZIP CODE: 21901	10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1966-1968	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Groundskeeper	16b. KIND OF BUSINESS/INDUSTRY: Federal Government	
17. FATHER'S NAME (First, Middle, Last): Hartley May		18. MOTHER'S NAME (First, Middle, Maiden Surname): Roshie Leftwhich	
19a. INFORMANT'S NAME (Type/Print): Mrs. Roshie L. May		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 505 Congress Avenue, Havre de Grace, MD 21078	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dreer Creek Harmony Cemetery	20c. LOCATION — City or Town, State: Darlington, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William S. Smith II		22. NAME AND ADDRESS OF FACILITY: Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CANCER OF BLADDER WITH METASTASES
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Joaquin R. Garcia M.D.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 24 August 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOAQUIN R. GARCIA, M.D. VAMC, PERRY POINT, MD. 21902		
31. DATE FILED (Month, Day, Year): AUG 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 24903

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mabel F Moody
2. DATE OF DEATH (Month, Day, Year): 8 14 89
3. TIME OF DEATH: 7:25A M
4. SOCIAL SECURITY NUMBER: 218-46-1636
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 84 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7-11-05
8. BIRTHPLACE (State or Foreign Country): Perryville
9a. FACILITY NAME (If not institution, give street and number): Calvert Manor Nrsg Home
9b. CITY, TOWN OR LOCATION OF DEATH: Rising Sun
9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Cecil
10c. CITY, TOWN OR LOCATION: Perryville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 608 Otsego St
10f. ZIP CODE: 21903
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Six Years — College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Harry F Hand
18. MOTHER'S NAME (First, Middle, Maiden Surname): Daisy Owens
19a. INFORMANT'S NAME (Type/Print): Barbara Brown.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 328 Perryville Md 21903
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Asbury Cemetery
20c. LOCATION — City or Town, State: Port Deposit, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ross A. Patterson Sr.
22. NAME AND ADDRESS OF FACILITY: Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
b. ARTERIOSCLEROTIC CARDIOVASCULAR DIS.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Rolando A. Najera
29c. LICENSE NUMBER: D07463
29d. DATE SIGNED (Month, Day, Year): ▶ 8-14-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Rolando A. Najera, M.D., 105 East Main Street, Elkton, Maryland 21921
31. DATE FILED (Month, Day, Year): AUG 17 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

12

89 24904

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RODNEY S. PURNER SR
2. DATE OF DEATH — MONTH: 8 DAY: 17 YEAR: 89
3. TIME OF DEATH: 9:45 AM
4. SOCIAL SECURITY NUMBER: 220-30-3921
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 81 YRS.
IF UNDER 1 YEAR — MONTHS: DAYS: IF UNDER 24 HRS. — HOURS: MIN.:
7. DATE OF BIRTH (Month, Day, Year): 9-30-07
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 215 W. MAIN
9b. CITY, TOWN OR LOCATION OF DEATH: CECILTON
9c. COUNTY OF DEATH: CECIL

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: CECIL
10c. CITY, TOWN OR LOCATION: CECILTON
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 215 W. MAIN
10f. ZIP CODE: 21913
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 10 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FARMER
16b. KIND OF BUSINESS/INDUSTRY: GRAIN
17. FATHER'S NAME (First, Middle, Last): WILLIAM PURNER
18. MOTHER'S NAME (First, Middle, Maiden Surname): CATHERINE SMITH
19a. INFORMANT'S NAME (Type/Print): RODNEY S. PURNER JR
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 LONG POINT BLVD FAIRLEE MD 21919
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SILVER BROOK CEMETERY
20c. LOCATION — City or Town, State: WILMINGTON DE
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert T Foard
22. NAME AND ADDRESS OF FACILITY: R.T. FOARD FUNERAL HOME CHESAPEAKE CITY MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio-Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Intra Scalp Hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):
c. Ch. Obstructive Pulmonary Dis
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D-04794
29d. DATE SIGNED (Month, Day, Year): 8/17/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E.M. ABLAMS, M.D. 233 BOW ST. ELKTON, MD. 21921
31. DATE FILED (Month, Day, Year): AUG 18 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24905 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 may be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THAKORBHAI C. PATEL				2. DATE OF DEATH: MONTH 8 DAY 15 YEAR 1989	3. TIME OF DEATH: 7:30 A.M
4. SOCIAL SECURITY NUMBER: -0-	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 54 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JAN. 24 1935	8. BIRTHPLACE (State or Foreign Country): INDIA
9a. FACILITY NAME (If not institution, give street and number): Union Hosp. Cecil County			9b. CITY, TOWN OR LOCATION OF DEATH: ELKTON MD		9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: ELKTON	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 615 E Pulaski Highway		10f. ZIP CODE: 21921	10g. CITIZEN OF WHAT COUNTRY? India

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECEHDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Hindu

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OWNER & Operator	16b. KIND OF BUSINESS/INDUSTRY: Motel

17. FATHER'S NAME (First, Middle, Last): CHHitubHAI Patel	18. MOTHER'S NAME (First, Middle, Maiden Surname): VAJYABEN
19a. INFORMANT'S NAME (Type/Print): DIWALIben Patel	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 615 E. Pulaski Hwy ELKton. Md 21921
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Silverbrook Crematory
20c. LOCATION — City or Town, State: Wilm. De.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward McKown	22. NAME AND ADDRESS OF FACILITY: Gee Funeral Home 259 E. main St. ELKton, md 21921

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter tha moda of dying, such as cerdiac or reapiratory arreat, ahock, or heart failure. List only ona cause on aach lina.

Approximeta Interval Between Onaet and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest

DUE TO (OR AS A CONSEQUENCE OF): Dead on Arrival —

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AHD TITLE OF CERTIFIER: Jayantilal K. Patel MD	29c. LICENSE HUMBER: D22307	29d. DATE SIGHED (Month, Day, Year): 8/16/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAYANTILAL K PATEL MD 123 Singerly Ave, ELKTON MD 21921

31. DATE FILED (Month, Day, Year): AUG 17 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

10

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24906

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be ... by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Kennard Wilson Pinder			2. DATE OF DEATH: MONTH 8 DAY 20 YEAR 89	3. TIME OF DEATH: 11:50 a M
4. SOCIAL SECURITY NUMBER: 218-20-3694	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4-21-25	8. BIRTHPLACE (State or Foreign Country): Chestertown, Md
9a. FACILITY NAME (If not institution, give street and number): Union Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Elkton		9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: Elkton	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 34 Pinder Avenue		10f. ZIP CODE: 21921	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW 2	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Production Line	16b. KIND OF BUSINESS/INDUSTRY: Trojan Boat Co.	
17. FATHER'S NAME (First, Middle, Last): T. Franklin Pinder		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mollie Emory	
19a. INFORMANT'S NAME (Type/Print): Nancy E. Byrd		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 983 Elkton, Md. 21921	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Elkton Cemetery	20c. LOCATION — City or Town, State: Elkton, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward McKeown	22. NAME AND ADDRESS OF FACILITY: Gee Funeral Home	259 E. Main Street, Elkton, Md. 21921	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute MI DUE TO (OR AS A CONSEQUENCE OF):	15 min ?
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	ASHD DUE TO (OR AS A CONSEQUENCE OF):	
c.	DUE TO (OR AS A CONSEQUENCE OF):	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic alcoholism addiction

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Peter Stravakis MD	29c. LICENSE NUMBER: D12192	29d. DATE SIGNED (Month, Day, Year) ▶ 8/20/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Peter Stravakis, M. D. Union Hospital, Elkton, Md. 21921		
31. DATE FILED (Month, Day, Year): AUG 22 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

6
+1 grits

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24907 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARION R. REYNOLDS
2. DATE OF DEATH (Month, Day, Year): 8 23 89
3. TIME OF DEATH: 10:40 PM
4. SOCIAL SECURITY NUMBER: 214-10-7297
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-10-04
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): UNION HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: ELKTON
9c. COUNTY OF DEATH: CECIL

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: CECIL
10c. CITY, TOWN OR LOCATION: CHESAPEAKE CITY
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 708 BIDDLE ST
10f. ZIP CODE: 21915
10g. CITIZEN OF WHAT COUNTRY?: U.S.A
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY: HOME
17. FATHER'S NAME (First, Middle, Last): GEORGE PAYNE
18. MOTHER'S NAME (First, Middle, Maiden Surname): MAGGIE MORGAN
19a. INFORMANT'S NAME (Type/Print): MARY R. BROWN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 913 BIDDLE ST. CHESAPEAKE CITY MD
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BETHEL
20c. LOCATION — City or Town, State: CHESAPEAKE CITY MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert J. Foard
22. NAME AND ADDRESS OF FACILITY: R.T. FOARD FUNERAL HOME CHESAPEAKE CITY MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. acute myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. generalized Arteriosclerotic vascular disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Diabetes mellitus.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD
29c. LICENSE NUMBER: D0 48 23
29d. DATE SIGNED (Month, Day, Year): 8/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joi Chih Hsu 223 West main St. Elkton Md 21921
31. DATE FILED (Month, Day, Year): AUG 25 '89
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24908
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the ... or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be retained as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOMINICK ROSS, SR.		2. DATE OF DEATH (Month, Day, Year): August 14, 1989	3. TIME OF DEATH: 12:32P M
4. SOCIAL SECURITY NUMBER: 294-20-8855	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 63 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 7, 1926
8. BIRTHPLACE (State or Foreign Country): Ohio			
9a. FACILITY NAME (If not institution, give street and number): V.A. Medical Center	9b. CITY, TOWN OR LOCATION OF DEATH: Perry Point	9c. COUNTY OF DEATH: Cecil	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: Port Deposit	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 277 Blythedale Road	10f. ZIP CODE: 21904	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married [XX] 3 Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: W.W. II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [XX] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Six Years; College (1-4 or 5+): ----	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bus Driver	16b. KIND OF BUSINESS/INDUSTRY: Inter-County Bus Lines Havre de Grace, Maryland	
17. FATHER'S NAME (First, Middle, Last): Angelo Ross, Sr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mae Orn		
19a. INFORMANT'S NAME (Type/Print): Dominick Ross, Jr.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 277 Blythedale Rd., Port Deposit, Md. 21904		
20a. METHOD OF DISPOSITION: [XX] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harford Memorial Gardens	20c. LOCATION — City or Town, State: Aberdeen, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ross J Patterson Sr	22. NAME AND ADDRESS OF FACILITY: Lee A. Patterson & Son Funeral Home Perryville, Maryland		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cancer of Esophagus with Metastasis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? [XX] 1 YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [XX] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: [XX] 1 Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Can Leung MD	29c. LICENSE NUMBER: D16608	29d. DATE SIGNED (Month, Day, Year): 8/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): K. K. LEUNG, M.D., V.A. Medical Center, Perry Point, Maryland 21902		
31. DATE FILED (Month, Day, Year): AUG 17 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

10
+1 grates
VA

#23&27FilmG655 9/6/89 kam

89 24909

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Judy Kay Rinehart		2. DATE OF DEATH (Month, Day, Year): 8-3-89	3. TIME OF DEATH: 1:22PM M
4. SOCIAL SECURITY NUMBER: 220-50-4972	5. SEX: 1 ☐ M 2 ☒ F XX	6. AGE (In yrs. last birthday): 41 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11-3-47
8. BIRTHPLACE (State or Foreign Country): Davy, W. Va.			
9a. FACILITY NAME (If not institution, give street and number): Union Hospital of Cecil County	9b. CITY, TOWN OR LOCATION OF DEATH: Elkton	9c. COUNTY OF DEATH: Cecil County	
RESIDENCE OF DECEDENT			
10a. STATE: Md.	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: Elkton	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 127 Friendship Road	10f. ZIP CODE: 21921	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced XX	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Food Service	16b. KIND OF BUSINESS/INDUSTRY: Job Corps	
17. FATHER'S NAME (First, Middle, Last): Howard Rhodes	18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace E. Chambers		
19a. INFORMANT'S NAME (Type/Print): Jimmie Rhodes	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 105 Seneca Ct., North East, Md. 21901		
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hopewell Cemetery	20c. LOCATION — City or Town, State: Rising Sun, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Gee Funeral Home 259 E. Main St., Elkton, Md. 21921		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? XXX YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 SSS YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient SSS/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	OCME	▶ 8-4-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 6 89	[signature]

DHMH-16 Rev 1/89

89 24910

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Cecelia E. Tomazine
2. DATE OF DEATH (Month, Day, Year): August 24 1989
3. TIME OF DEATH: 7:35 p M
4. SOCIAL SECURITY NUMBER: 222-12-6823
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 62 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 8, 1926
8. BIRTHPLACE (State or Foreign Country): Wilm., De.
9a. FACILITY NAME (If not institution, give street and number): 59 Hilltop Road
9b. CITY, TOWN OR LOCATION OF DEATH: Elkton
9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Cecil
10c. CITY, TOWN OR LOCATION: Elkton
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 59 Hilltop Road
10f. ZIP CODE: 21921
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): William Finney
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Lux Finney
19a. INFORMANT'S NAME (Type/Print): G. Michael Mayew
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 233 Steeplechase Circle Wilm., De. 19808
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gracelawn Memorial Park
20c. LOCATION — City or Town, State: New Castle, De.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Nicholas R. Gentile MO0788
22. NAME AND ADDRESS OF FACILITY: Mc Crery Funeral Home, INc. 3924 Concord Pike Wilm., De. 19803

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. Cancer of the Rectum	8/9/89
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: C1000964
29d. DATE SIGNED (Month, Day, Year): 8/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Timothy F. Wozniak, M.D. 1700 Shallcross Ave. Wilm., De. 19805
31. DATE FILED (Month, Day, Year): August 25, 1989
32. REGISTRAR'S SIGNATURE: AUG 25 '89 [signature]

DHMH-16 Rev 1/89

8

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24911
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
Anna	Roberta	Bowman	August 24 1989	10:43 AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
220-16-5303A	1 ☐ M 2 ☒ F	101 YRS.			MARCH 23, 1888	MARYLAND

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Physicians Memorial Hospital	La Plata	Charles

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND	CHARLES	POMFRET	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
ROUTE #2 BOX 74 R 1	20675	UNITED STATES

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Ricen, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: BLACK

15. DECEOENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
7TH GRADE	NONE	BEAUTICIAN	PRIVATE

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
CHARLES H. BROWN	CHARITY ANN BIVINS

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
THERESA E. CHASE	ROUTE #2 BOX 74-R-1 POMFRET, MARYLAND 20675

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ST. JOSEPH'S CHURCH CEMETERY	POMFRET, MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Lydia C. Thornton Johnson	THORNTON'S FUNERAL HOME POMONKEY, MARYLAND 20640

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Septicemia Secondary to	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Urinary tract disease.	
	c.	
	d.	

DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D25992	▶ 8/24/89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Khadar Baig Box 190-301 South La Plata, Maryland 20646

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 '89	Julia Davidson-Randall

DHMH-18 Rev 1/89

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24912
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margaret Viola Cooksey			2. DATE OF DEATH: Month August Day 28, 1989	3. TIME OF DEATH: 5:10 A.M.
4. SOCIAL SECURITY NUMBER: 217-46-5360	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10/22/1911	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Physicians Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: LaPlata		9c. COUNTY OF DEATH: Charles

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: Newburg	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 1 , Box 112 F		10f. ZIP CODE: 20664	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker	16b. KIND OF BUSINESS/INDUSTRY: At Home	
17. FATHER'S NAME (First, Middle, Last): George Henry Murphy		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret D. Pilkerton	
19a. INFORMANT'S NAME (Type/Print): Margaret Alice Bryant	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1, Box 112 F, Newburg, Maryland 20664		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): United Methodist Cemetery	20c. LOCATION — City or Town, State: Dentsville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J. C. Echols Jr	22. NAME AND ADDRESS OF FACILITY: Arehart Funeral Home, Inc. P.O. Box 567, La Plata, Md. 20646		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. sepsis	10 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute Urinary Tract Infection, Strep. faecalis	10 days
DUE TO (OR AS A CONSEQUENCE OF):		
	c. Febrile seizures	3 days
DUE TO (OR AS A CONSEQUENCE OF):		
	d. Atrial Fibrillation	10 yrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Arteriosclerosis, Diabetes mellitus, ASHD, Parkinson's Disease, Seizure disorder, Anemia, Hypertension

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY: N/A M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO N/A	28d. DESCRIBE HOW INJURY OCCURED: N/A
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Pritchett Jr MD	29c. LICENSE NUMBER: D 8370	29d. DATE SIGNED (Month, Day, Year): ▶ AUG. 28, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Paul E. Pritchett 118 LaGrange Ave. P.O. Box 1317 LaPlata, Md 20646		
31. DATE FILED (Month, Day, Year): AUG 29 '89	32. REGISTRAR'S SIGNATURE: Jacha Davidson-Randall	

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24913

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Doris E. Conner
2. DATE OF DEATH (Month, Day, Year): 7 - 31 - 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 213-22-6092
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 61 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 4 - 2 - 28
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Rt. 1 Box 112
9b. CITY, TOWN OR LOCATION OF DEATH: Rhodesdale
9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Dorchester
10c. CITY, TOWN OR LOCATION: Rhodesdale
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt 1 Box 112
10f. ZIP CODE: 21659
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): Secondary — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): laborer
16b. KIND OF BUSINESS/INDUSTRY: Solo Cup Co.
17. FATHER'S NAME (First, Middle, Last): Elwood Sheppard
16. MOTHER'S NAME (First, Middle, Maiden Surname): Lula Evans
19a. INFORMANT'S NAME (Type/Print): Sandra Nuton
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1 Box 112 Rhodesdale, MD 21659
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Federal Hill
20c. LOCATION — City or Town, State: Federalsburg, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bennie L. Smith
22. NAME AND ADDRESS OF FACILITY: Bennie Smith Services PO Box 928 Hurlock, MD 21643

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Metastatic Carcinoma of Lung — Approximate Interval: days
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Carcinoma of Lung — Approximate Interval: Months
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: David B. Stoeckle
29c. LICENSE NUMBER: D 23411
29d. DATE SIGNED (Month, Day, Year): ▶August 22, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David B. Stoeckle, M.D., 200 Maryland Avenue, Cambridge, Maryland 21613
31. DATE FILED (Month, Day, Year): AUG 28 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-24914

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELLEN LEIGH DYSON		2. DATE OF DEATH (Month, Day, Year): AUGUST 28, 1989	3. TIME OF DEATH: 4:41 A M
4. SOCIAL SECURITY NUMBER: 579-42-8165	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 03-23-33	8. BIRTHPLACE (State or Foreign Country): Pennsylvania		
9a. FACILITY NAME (If not institution, give street and number): PHYSICIANS MEMORIAL HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: LA PLATA	9c. COUNTY OF DEATH: CHARLES	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: Nanjemoy	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Route 1 Box 12	10f. ZIP CODE: 20662	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker	16b. KIND OF BUSINESS/INDUSTRY: At Home	
17. FATHER'S NAME (First, Middle, Last): Paul Gallitzin John Richardson	18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Marie Carson		
19a. INFORMANT'S NAME (Type/Print): Colleen Fryberger	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1187 16th St., San Diego, Calif. 92154		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Trinity Memorial Gardens	20c. LOCATION — City or Town, State: Waldorf, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Hunter C. Echols III	22. NAME AND ADDRESS OF FACILITY: Arehart Funeral Home, Inc. La Plata, Maryland 20646-0567		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Septic shock	24 hrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Group B Strep. Meningitis	18 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Pseudomembranous colitis	10 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Disseminated intravascular coagulopathy	24 hrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Adult Respiratory Destress Syndrome, peptic ulcer disease, Hypertension, coronary artery disease, Type II Diabetes mellitus, Peripheral Vascular Disease, COPD, UTI

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO N/A

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY: N/A AM	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO N/A	28d. DESCRIBE HOW INJURY OCCURED: N/A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Pritchett M.D.	29c. LICENSE NUMBER: D 8370	29d. DATE SIGNED (Month, Day, Year): ▶ AUG 28, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
20646
RXRK PAUL E. PRITCHETT M.D. 118 LA GRANGE AVE. POB 1317 LA PLATA, MARYLAND

31. DATE FILED (Month, Day, Year): AUG 31 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 · FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89-24915 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Leo Forbes			2. DATE OF DEATH (Month, Day, Year): 8-24-89	3. TIME OF DEATH: 5:15AM M
4. SOCIAL SECURITY NUMBER: 213-78-2446	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 29 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 23, 1960	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): MD St Rt 257 (Rock Point Rd.)		9b. CITY, TOWN OR LOCATION OF DEATH: Issue	9c. COUNTY OF DEATH: Charles County	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: CHARLES	10c. CITY, TOWN OR LOCATION: CHARLOTTE HALL	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Route 1 Box 251A		10f. ZIP CODE: 20622	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): ELEVENTH; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER	16b. KIND OF BUSINESS/INDUSTRY: PRIVATE	
17. FATHER'S NAME (First, Middle, Last): THEODORE MILLS EDELEN		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY EUGENIA FORBES	
19a. INFORMANT'S NAME (Type/Print): MARY E. FORBES		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 234 R.R. 1 Box 251-A Charlotte Hall, Maryland	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOLY GHOST CHURCH CEMETERY	20c. LOCATION — City or Town, State: ISSUE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leon Thornton		22. NAME AND ADDRESS OF FACILITY: THORNTON FUNERAL HOME POMONKEY, MARYLAND	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ee cerdiac or respiratory srrest, shock, or haart feilure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify): Scene	
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-24-89	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
	28d. DESCRIBE HOW INJURY OCCURED: PEDESTRIAN STRUCK BY PICK UP		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): MD St. Rt. 257 (Rock Point Rd) Charles County, Maryland	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 8-24-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201 VC		
31. DATE FILED (Month, Day, Year): AUG 29 '89	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24916 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Deborah R. Mariano Garrett			2. DATE OF DEATH (Month, Day, Year): 8-20-89	3. TIME OF DEATH: 10:30PM M
4. SOCIAL SECURITY NUMBER: 213-78-9144	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 30 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 21, 1959	8. BIRTHPLACE (State or Foreign Country): Balt. Maryland
9a. FACILITY NAME (If not institution, give street and number): Fishing Creek		9b. CITY, TOWN OR LOCATION OF DEATH: Golden Hill	9c. COUNTY OF DEATH: Dorchester Co.	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Charlotte Hall	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rte 2 Box 138		10f. ZIP CODE: 20622	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LPN Nurse	16b. KIND OF BUSINESS/INDUSTRY: Nursing	
17. FATHER'S NAME (First, Middle, Last): Joseph James Mariano		18. MOTHER'S NAME (First, Middle, Maiden Surname): Alma Jean Dingus	
19a. INFORMANT'S NAME (Type/Print): William D. Garrett		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2020 Belfast Dr. Ft. Washington Md 20744	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lee Crematory	20c. LOCATION — City or Town, State: Clinton, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeruanne E Bates		22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old ALexander Ferry Rd Clinton, Md 20735	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Scene		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-20-89	28b. TIME OF INJURY: 9:20PM	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: Victim of plane crash
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): plane			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Fishing Creek, Dorchester Co., Maryland

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell, M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-21-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201 VC

31. DATE: AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

UNKNOWN 89-145

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24917

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gregory W. Garrett, Jr.
2. DATE OF DEATH (Month, Day, Year): 8-20-89
3. TIME OF DEATH: 10:30PM M
4. SOCIAL SECURITY NUMBER: N/A
5. SEX: 1 XX M 2 ☐ F
6. AGE (In yrs. last birthday): YRS.
IF UNDER 1 YEAR: MONTHS 4 DAYS 23
IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-26-89
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Fishing Creek,-off Rt. 335-woods
9b. CITY, TOWN OR LOCATION OF DEATH: Golden Hill
9c. COUNTY OF DEATH: Dorchester County

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: St. Mary's
10c. CITY, TOWN OR LOCATION: Charlotte Hall
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO
10e. STREET AND NUMBER: Rt. 2, Box 138
10f. ZIP CODE: 20622
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES XX NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A
16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): Gregory W. Garrett
18. MOTHER'S NAME (First, Middle, Maiden Surname): Deborah R. Mariano
19a. INFORMANT'S NAME (Type/Print): William D. Garrett
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2020 Belfast Dr.,Ft.Wash.,M.D. 20744
20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cem.
20c. LOCATION — City or Town, State: Clinton,Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeriann E. Bates
22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home,Inc. 6633 Old Alexander Ferry Road Clinton,Md. 20735

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 XX Other (Specify) Scene
27. MANNER OF DEATH: 1 ☐ Natural 2 XX Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 8-20-89
28b. TIME OF INJURY: 9:20P M
28c. INJURY AT WORK? 1 ☐ YES 2 XX NO
28d. DESCRIBE HOW INJURY OCCURED: Victim of plane crash
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Wooded area
28f. LOCATION (Street and Number or Rural Route Number, City, Town, State): Fishing Creek off Rt. 335-woods Dorchester County, Maryland
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 8-21-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell,M.D. 111 Penn Street,Baltimore,MD 21201
31. DATE FILED (Month, Day, Year): AUG 25 '89
REGISTRAR: Julia Davidson-Randall

(6)

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 21,918

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gregory William Garrett			2. DATE OF DEATH (Month, Day, Year): 8-20-89	3. TIME OF DEATH: 10:30PM M
4. SOCIAL SECURITY NUMBER: 214-68-8667	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 34 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 8,1955	8. BIRTHPLACE (State or Foreign Country): Washington DC
9a. FACILITY NAME (If not institution, give street and number): Fishing Creek-Wooded area off Rt. 335		9b. CITY, TOWN OR LOCATION OF DEATH: Golden Hill	9c. COUNTY OF DEATH: Dorchester County	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Charlotte Hall	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [XX] NO	
10e. STREET AND NUMBER: Rt 2 Box 138		10f. ZIP CODE: 20622	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [XX] NO IF YES, GIVE WAR OR DATES	13. WAS DECEHDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] HO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): 4		16a. DECEDEHT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Computer Accoutant	16b. KIND OF BUSIHESS/IHDUSTRY: Telcom.	
17. FATHER'S HAME (First, Middle, Last): William Donaldson Garrett		18. MOTHER'S HAME (First, Middle, Maiden Surname): Doris A. McCall		
19a. IHFORMANT'S NAME (Type/Print): William D. Garrett		19b. MAILIHG ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2020 Belfast Drive Ft. Washington, Md 20744		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cemetery	20c. LOCATION — City or Town, State: Clinton, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. HAME AHD ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old AlexanderFerry Rd Clinton Md 20735		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries	
	DUE TO (OR AS A COHSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUEHCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUEHCE OF):	
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AH AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
XX YES 2 [ ] HO	XX YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMIHER?	26. PLACE OF DEATH (Check only one)
XXX YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [XX] Other (Specify) Scene

27. MAHHER OF DEATH	28a. DATE OF IHJURY (Month, Day, Year)	28b. TIME OF IHJURY	28c. IHJURY AT WORK?	28d. DESCRIBE HOW IHJURY OCCURED
1 [ ] Natural; XXX 2 [X] Accident; 3 [ ] Suicide; 4 [ ] Homicide; 5 [ ] Pending investigation; 6 [ ] Could not be determined	8-20-89	9:20PM	1 [ ] YES 2 [XX] NO	Victim of plane crash
	28e. PLACE OF IHJURY — At home, ferm, street, factory, office building, etc. (Specify): wooded area			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Fishing Creek off Rt. 335,woods Dorchester County, Maryland

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAH: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XXX MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the ceuse(s) end menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE HUMBER	29d. DATE SIGNED (Month, Day, Year)
Margarita A. Korell	OCME	8-21-89

30. HAME AHD ADDRESS OF PERSOH WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print): Margarita A. Korell,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24919

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELSIE B HALL					2. DATE OF DEATH (Month, Day, Year): July 23 1989			3. TIME OF DEATH: 7:10 p.m.
4. SOCIAL SECURITY NUMBER: 220-01-9195	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): DEC. 10, 1901			8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): PHYSICIANS MEMORIAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: LA PLATA				9c. COUNTY OF DEATH: CHARLES	
RESIDENCE OF DECEDENT								
10a. STATE: MARYLAND	10b. COUNTY: DORCHESTER		10c. CITY, TOWN OR LOCATION: EAST NEW MARKET				10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: RAILROAD AVENUE			10f. ZIP CODE: 21631				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CAFETERIA MANAGER				16b. KIND OF BUSINESS/INDUSTRY: SCHOOL SYSTEM	
17. FATHER'S NAME (First, Middle, Last): JAMES E. BOSTON					18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET PHILLIPS			
19a. INFORMANT'S NAME (Type/Print): FLETCHER R. HALL			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 W. UNIVERSITY PARKWAY, APT. 5C, BALTIMORE, MD 21210					
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): EAST NEW MARKET CEMETERY				20c. LOCATION — City or Town, State: EAST NEW MARKET, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leonard O. Zeller			22. NAME AND ADDRESS OF FACILITY: ZELLER FUNERAL HOME EAST NEW MARKET, MD 21631					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ACUTE CARDIAC ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CORONARY ARTERY DISEASE	4 years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Krishan M. Mathur MD	D28352	▶ 7-24-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KRISHAN MATHUR, M.D. Charles Professional Building Waldorf, Maryland 20601

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 10 '89	Githa Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24920
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Paul JONES			2. DATE OF DEATH (Month / Day / Year): 08 / 16 / 89	3. TIME OF DEATH: 2240 M
4. SOCIAL SECURITY NUMBER: 214-42-8664	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 8/14/1909	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Dorchester General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge		9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Cambridge	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 10 Bellevue Avenue		10f. ZIP CODE: 21613	10g. CITIZEN OF WHAT COUNTRY?: US

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Educator	16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): William Flowers Jones		18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Insley	
19a. INFORMANT'S NAME (Type/Print): S. Elizabeth Jones		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Bellevue Avenue	
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Old Trinity Churchyard	20c. LOCATION — City or Town, State: Church Creek, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John W. Thomas		22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home 700 Locust St. Cambridge, Md. 21613	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. cardio-pulmonary arrest	55"
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. congestive heart failure DUE TO (OR AS A CONSEQUENCE OF):	6mos
	c. atrial fibrillation DUE TO (OR AS A CONSEQUENCE OF):	6mos
	d. myocardial infarction	over 1yr

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles M. Briggs MD	29c. LICENSE NUMBER: D27184	29d. DATE SIGNED (Month, Day, Year): ▶ 16 AUG 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): AUG 18 89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

89 24921

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Madeline Kramer			2. DATE OF DEATH (Month, Day, Year): Aug. 17, 1989	3. TIME OF DEATH: 3:30 P M
4. SOCIAL SECURITY NUMBER: 212-74-6973	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8/17/1905	8. BIRTHPLACE (State or Foreign Country): WestVirginia
9a. FACILITY NAME (If not institution, give street and number): Dorchester General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge		9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Cambridge	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: Bay Country Village, 102 Glenburn Ave., Apt. #2		10f. ZIP CODE: 21613	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White/Caus.

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4 yrs.college	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: Education
17. FATHER'S NAME (First, Middle, Last): Phillip Dougherty		18. MOTHER'S NAME (First, Middle, Maiden Surname): Harriet Hammer	
19a. INFORMANT'S NAME (Type/Print): John Dougherty (nephew)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 709 Lincoln St., Cumberland, MD. 21502	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Old Trinity	20c. LOCATION — City or Town, State: Church Creek, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Colleen Curran-Tramwell		22. NAME AND ADDRESS OF FACILITY: Curran Funeral Home, 308 High St., Cambridge, MD. 21613	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Inferior myocardial Infarction	2 hours
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASCVD	
	c.	
	d.	

DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HBP

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Nubuty Jeen MD	29c. LICENSE NUMBER: D22773	29d. DATE SIGNED (Month, Day, Year): ▶ 8/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Nubuty Jeen MD	503 BYRN ST. CAMB Md	
31. DATE FILED (Month, Day, Year): AUG 18 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

SHERIDAN PENNINGTON

89 24922

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sheridan Pennington				2. DATE OF DEATH: MONTH 08 DAY 14 YEAR ~~89~~	3. TIME OF DEATH: 3:46 PM
4. SOCIAL SECURITY NUMBER: 217-05-7934	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 6 15 1915	8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): Dorchester General			9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge		9c. COUNTY OF DEATH: Dorchester
RESIDENCE OF DECEDENT					
10a. STATE: Md.	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Cambridge			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 714 Lincoln Terrace		10f. ZIP CODE: 21613			10g. CITIZEN OF WHAT COUNTRY? U. S. A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Secondary; College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer			16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Julian Pennington				18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Pennington	
19a. INFORMANT'S NAME (Type/Print): Myrtle Virginia Pennington		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 714 Lincoln Terrace Cambridge, Md. 21613			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Md. Veterans		20c. LOCATION — City or Town, State: Beulah, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bennie L. Smith		22. NAME AND ADDRESS OF FACILITY: B.S.F.H. P.O. Box 928 Hurlock, Md.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease — Years

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of Gall Bladder with Metastases
CBD Obstruction due to Cancer, Multiple old Myocardial infarctions, Emphysema, Ascites due to Cancer

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
James F. McCarter M.D. DEPUTY MEDICAL EXAM.	D 07052	▶ 8-17-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James F. McCarter, M.D. 400 Aurora St. Cambridge, Md. 21613

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 28 '89	Julia Davidson-Randall

OHMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4

89 24923

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SPENCER EDWARD PLATER, JR.				2. DATE OF DEATH: MONTH 8 DAY 24 YEAR 89	3. TIME OF DEATH: 10:15 AM
4. SOCIAL SECURITY NUMBER: 220-78-2392	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 27 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): DEC.20,1961	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): St. Charles Pky, 1/4 ml. W. of Rt. 5			9b. CITY, TOWN OR LOCATION OF DEATH: Waldorf		9c. COUNTY OF DEATH: Charles

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: ST. MARY'S CO.	10c. CITY, TOWN OR LOCATION: MECHANICSVILLE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: RT. 4, BOX 6		10f. ZIP CODE: 20659	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH. GRADE; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER	16b. KIND OF BUSINESS/INDUSTRY: CONSTRUCTION	
17. FATHER'S NAME (First, Middle, Last): SPENCER EDWARD PLATER, SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET E. JENIFER	
19a. INFORMANT'S NAME (Type/Print): MARGARET E. PLATER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT. 4, BOX 6, MECHANICSVILLE, MD. 20659	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHARLES MEMORIAL GARDENS	20c. LOCATION — City or Town, State: LEONARDTOWN, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: David A. Simmons		22. NAME AND ADDRESS OF FACILITY: MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD.20650	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) scene			
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-24-89	28b. TIME OF INJURY: 9:13A M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: passenger of auto/fixed object impact
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): street			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): St. Charles Pky, 1/4 ml. W. of Rt. 5

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles P. Kokes MD	29c. LICENSE NUMBER: OCMe	29d. DATE SIGNED (Month, Day, Year): ▶ 8-24-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn Street Baltimore, MD. 21201		
31. DATE FILED (Month, Day, Year): AUG 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 24924

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Everett Lee Reese					2. DATE OF DEATH (Month, Day, Year): August 21,1989	3. TIME OF DEATH: 2:30P. M
4. SOCIAL SECURITY NUMBER: 178-09-5554	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9-11-1904	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): 2 Irving Place,Potomac Heights			9b. CITY, TOWN OR LOCATION OF DEATH: Indian Head		9c. COUNTY OF DEATH: /Charles	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: Indian Head	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: # 2 Irving Place		10f. ZIP CODE: 20640	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4 or 5+): -	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanical Inspector	16b. KIND OF BUSINESS/INDUSTRY: DC Government	
17. FATHER'S NAME (First, Middle, Last): Elmer Reese		18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Davis	
19a. INFORMANT'S NAME (Type/Print): Mildred L. Reese		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): #2 Irving Place, Indian Head, Md. 20640	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Trinity Memorial Gardens	20c. LOCATION — City or Town, State: Waldorf, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward G. Mudd		22. NAME AND ADDRESS OF FACILITY: Huntt Funeral Home P. O. Box 156, Waldorf, Md. 20604	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory Failure	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Small Cell Carcinoma of the Lung	1-2 months
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	26d. DESCRIBE HOW INJURY OCCURED
	26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D33426	29d. DATE SIGNED (Month, Day, Year): August 21,1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr.B. Larry Jenkins Pembrooke Square#104 Waldorf, Md. 20601

31. DATE FILED (Month, Day, Year): AUG 23 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24925 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Therese (Peyton) Seneschal
2. DATE OF DEATH (Month, Day, Year): 08 22 1989
3. TIME OF DEATH: 8:30 PM
4. SOCIAL SECURITY NUMBER: 556-74-1330
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 40 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 03-24-49
8. BIRTHPLACE (State or Foreign Country): California
9a. FACILITY NAME (If not institution, give street and number): 12 Partridge Court
9b. CITY, TOWN OR LOCATION OF DEATH: La Plata
9c. COUNTY OF DEATH: Charles

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Charles
10c. CITY, TOWN OR LOCATION: La Plata
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 12 Partridge Court
10f. ZIP CODE: 20646
10g. CITIZEN OF WHAT COUNTRY?: U. S. A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker
16b. KIND OF BUSINESS/INDUSTRY: At Home
17. FATHER'S NAME (First, Middle, Last): Robert Joseph Peyton
18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Mary Flood
19a. INFORMANT'S NAME (Type/Print): Phillip G. Seneschal
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Partridge Ct., La Plata, Md. 20646
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart Cemetery
20c. LOCATION — City or Town, State: La Plata, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph Burton Sites
22. NAME AND ADDRESS OF FACILITY: Arehart Funeral Home, Inc. La Plata, Maryland 20646

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	STROKE - BRAIN METASTASES	1 DAY
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	METASTATIC CANCER	1 + YR
DUE TO (OR AS A CONSEQUENCE OF):		
c.	BREAST CANCER	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Stanley A Schwartz MD
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stanley A. Schwartz, M.D., 2101 Med. Park Dr., Silver Spring, Md. 20902
31. DATE FILED (Month, Day, Year): AUG 24 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24926

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Roland Russell Sasscer				2. DATE OF DEATH (Month, Day, Year): August 23 1989	3. TIME OF DEATH: 3:25 P M
4. SOCIAL SECURITY NUMBER: 577-14-8577	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5-10-1907	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Physicians Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: La Plata		9c. COUNTY OF DEATH: Charles

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: La Plata	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 106 Quail Court		10f. ZIP CODE: 20646	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): -	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cashier -Vice Pres.	16b. KIND OF BUSINESS/INDUSTRY: Banking	
17. FATHER'S NAME (First, Middle, Last): Charles Sasscer		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ellen Thompson	
19a. INFORMANT'S NAME (Type/Print): Jean Trueman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19906 Aquasco Rd., Aquasco, Md. 20608		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Trinity Memorial Gardens	20c. LOCATION — City or Town, State: Waldorf, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Willie R Blanks	22. NAME AND ADDRESS OF FACILITY: Huntt Funeral Home P. O. Box 156, Waldorf, Md. 20604-0156		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Collapse	3m
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Meningitis	1 day
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Pneumonia	3 day
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Abdominal infection	6 day

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Arthur O. Wooddy M.D.	29c. LICENSE NUMBER: D11176	29d. DATE SIGNED (Month, Day, Year): ▶ 08-23-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Arthur O. Wooddy, M.D. 100 Washington Ave. Old Town Hall Bldg. La Plata, Maryland 20646

31. DATE FILED (Month, Day, Year): AUG 25 89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 24927

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JEAN LOU THOMAS		2. DATE OF DEATH (Month, Day, Year): August 21, 1989	3. TIME OF DEATH: 7:30 a^M
4. SOCIAL SECURITY NUMBER: 579-22-4328	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 17, 1912
8. BIRTHPLACE (State or Foreign Country): VIRGINIA			
9a. FACILITY NAME (If not institution, give street and number): RESIDENCE 49 Oriole Lane	9b. CITY, TOWN OR LOCATION OF DEATH: Bel Alton	9c. COUNTY OF DEATH: Charles	
RESIDENCE OF DECEDENT			
10a. STATE: MARYLAND	10b. COUNTY: CHARLES	10c. CITY, TOWN OR LOCATION: BEL ALTON	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 49 ORIOLE LANE	10f. ZIP CODE: 20611	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th GRADE; College (1-4 or 5+): NONE	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NURSE'S AIDE	16b. KIND OF BUSINESS/INDUSTRY: PRIVATE	
17. FATHER'S NAME (First, Middle, Last): ARTHUR PARKER	18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY PITTS		
19a. INFORMANT'S NAME (Type/Print): AUDREY WRIGHT	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 49 Oriole Lane BelAlton, Maryland 20611		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LINCOLN MEMORIAL CEMETERY	20c. LOCATION — City or Town, State: SUITLAND, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lydia C Thornton Johnson	22. NAME AND ADDRESS OF FACILITY: THORNTON FUNERAL HOME POMONKEY, MD. 20640		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio Pulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):
Cancer of the Uterus

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. w/ Metasis to the Intestinal Tract
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael A Leatherwood, MD	29c. LICENSE NUMBER: D21031	29d. DATE SIGNED (Month, Day, Year): ▶ 8-21-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael A. Leatherwood, M.D. PO Box 249 Waldorf, MD 20604

31. DATE FILED (Month, Day, Year): AUG 23 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 24928

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LOUIS JEROME TRAVERS			2. DATE OF DEATH (Month, Day, Year): AUGUST 24, 1989	3. TIME OF DEATH: 6:12 A M
4. SOCIAL SECURITY NUMBER: 217-36-6989	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 58 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): MAY 28, 1930	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): PHYSICIANS MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: LA PLATA		9c. COUNTY OF DEATH: CHARLES

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: CHARLES	10c. CITY, TOWN OR LOCATION: LA PLATA	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: #1 HICKORY LANE #315		10f. ZIP CODE: 20646	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE; College (1-4 or 5+): NONE	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BUILDER	16b. KIND OF BUSINESS/INDUSTRY: PRIVATE	
17. FATHER'S NAME (First, Middle, Last): UNKNOWN		18. MOTHER'S NAME (First, Middle, Maiden Surname): PEARLINE TRAVERS	
19a. INFORMANT'S NAME (Type/Print): PAUL A. WOOD	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1407 HYDE COURT WALDORF, MARYLAND 20601		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. JOSEPH'S CHURCH CEMETERY	20c. LOCATION — City or Town, State: POMFRET, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lydia C. Hunter Johnson	22. NAME AND ADDRESS OF FACILITY: THORNTON'S FUNERAL HOME POMONKEY, MARYLAND 20640		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ATHEROSCLEROTIC HEART	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DISEASE, CONGESTIVE HEART	YRS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive lung disease.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [/] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [/] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [/] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Krishan M. Mathur MD	29c. LICENSE NUMBER: D28352	29d. DATE SIGNED (Month, Day, Year): ▶ 8/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KRISHAN M. MATHUR M.D. 445 ELLENWOOD DR. LA PLATA, MARYLAND 20646

31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 24929

1 - FOR STATE REGISTRAR IDA JOSEPHINE TROWBRIDGE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ida J. Trowbridge			2. DATE OF DEATH (Month, Day, Year): AUG 22 1989	3. TIME OF DEATH: 2:10 AM
4. SOCIAL SECURITY NUMBER: 579-60-1862	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-7-1901	8. BIRTHPLACE (State or Foreign Country): Kansas
9a. FACILITY NAME (If not institution, give street and number): Charles County Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: La Plata		9c. COUNTY OF DEATH: Charles

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: White Plains	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 2 Box 308		10f. ZIP CODE: 20695	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk	16b. KIND OF BUSINESS/INDUSTRY: US Government	
17. FATHER'S NAME (First, Middle, Last): Henry Pelzl		18. MOTHER'S NAME (First, Middle, Maiden Surname): Agnes Walters	
19a. INFORMANT'S NAME (Type/Print): Robert Trowbridge		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2 Box 308, White Plains, Md. 20695	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery	20c. LOCATION — City or Town, State: Suitland, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward A. Mudd		22. NAME AND ADDRESS OF FACILITY: Huntt Funeral Home P. O. Box 156, Waldorf, Md. 20604-0156	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cerebral infarction	10 min
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	arteriosclerosis	25 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.	hypertension	10 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
d.	Seizure disorder	5 yrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: anemia, multiple ventral hernias, COPD, multiple cerebral infarcts, sleep septicemia, organic brain syndrome.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	N/A

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY: N/A	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO N/A	28d. DESCRIBE HOW INJURY OCCURED: N/A
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A

29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D 8370	29d. DATE SIGNED (Month, Day, Year): ▶AUG 22, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):

31. DATE FILED (Month, Day, Year): AUG 25 89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 24930

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thurman Eddie Thompson			2. DATE OF DEATH (Month, Day, Year): August 22 1989	3. TIME OF DEATH: 5:45 PM
4. SOCIAL SECURITY NUMBER: 578-24-3106	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 94 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 02/06/1895	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Physicians Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: La Plata	9c. COUNTY OF DEATH: Charles	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: La Plata	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 56- 301 South		10f. ZIP CODE: 20646	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WW 1	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer	16b. KIND OF BUSINESS/INDUSTRY: Farming	
17. FATHER'S NAME (First, Middle, Last): William Henry Thompson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Florence Wright	
19a. INFORMANT'S NAME (Type/Print): Idell Pearl Thompson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 56- 301 South , La Plata,Md. 20646	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Trinity Memorial Gardens	20c. LOCATION — City or Town, State: Waldorf , Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J C Echols D		22. NAME AND ADDRESS OF FACILITY: Arehart Funeral Home, Inc. P.O. Box 567 ,La Plata,Md. 20646	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac Arrest	1hr 45m
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Arteriosclerotic Cardiovascular disease.	10yrs.
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A Wooddy MD	29c. LICENSE NUMBER: D11176	29d. DATE SIGNED (Month, Day, Year): ▶ 08-22-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Arthur O Wooddy, M.D. 100 Washington Ave. Old Town Hall Bldg. La Plata, Maryland 20646

31. DATE FILED (Month, Day, Year): AUG 24 '89	32. REGISTRAR'S SIGNATURE: Gina Davidson-Kimble

DHMH-16 Rev 1/89

89 24931

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 of 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna L. Underwood ANNA LOUISE UNDERWOOD
2. DATE OF DEATH (Month, Day, Year): August 26 1989
3. TIME OF DEATH: 3:15 PM
4. SOCIAL SECURITY NUMBER: 577 18 7058
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 5 1906
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Physicians Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: LaPlata
9c. COUNTY OF DEATH: Charles

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Charles
10c. CITY, TOWN OR LOCATION: Waldorf
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 29 Ell Lane
10f. ZIP CODE: 20602
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: NO
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: NO
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+): -------
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MANAGER
16b. KIND OF BUSINESS/INDUSTRY: FOOD SERVICES
17. FATHER'S NAME (First, Middle, Last): ANDREW PETERSEN
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIE NEILSEN
19a. INFORMANT'S NAME (Type/Print): ELLEN PETERSON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29 Ell Lane, Waldorf, Md. 20602
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Shilo Methodist Cemetery
20c. LOCATION — City or Town, State: Bryans Rd. Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Huntt Funeral Home, Inc. P.O. Box 156 Waldorf, Md. 20604

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Obliterative Atherosclerosis	20 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b.	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D2975
29d. DATE SIGNED (Month, Day, Year): 8-24-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Daniel Howell, M.D. Pembrooke Square #104, Waldorf, Maryland 20603
31. DATE FILED (Month, Day, Year): AUG 29 89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24932 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Edward Willett			2. DATE OF DEATH (Month, Day, Year): August 17 1989	3. TIME OF DEATH: 10:30 PM
4. SOCIAL SECURITY NUMBER: 212-12-5628	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): ~~77~~ 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4-5-13	8. BIRTHPLACE (State or Foreign Country): MD, USA
9a. FACILITY NAME (If not institution, give street and number): Physicians Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: La Plata		9c. COUNTY OF DEATH: Charles
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: La Plata		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: P O Box 456		10f. ZIP CODE: 20646		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th grade; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Improvement		16b. KIND OF BUSINESS/INDUSTRY: Self
17. FATHER'S NAME (First, Middle, Last): Dudley Willett		18. MOTHER'S NAME (First, Middle, Maiden Surname): unavailable		
19a. INFORMANT'S NAME (Type/Print): Kay Willett		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P O Box 2341, La Plata, MD 20646		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Trinity Memorial Gardens		20c. LOCATION — City or Town, State: Waldorf, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward G. Medd		22. NAME AND ADDRESS OF FACILITY: The Huntt Funeral Home P O Box 156, Waldorf, MD 20604		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Respiratory Failure — DUE TO (OR AS A CONSEQUENCE OF):
b. COPD — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D 02575	29d. DATE SIGNED (Month, Day, Year): ▶ 8-18-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DANIEL HOWELL M.D. PEMBROOKE SQUARE, #104 WALDORF, MARYLAND 20602		
31. DATE FILED (Month, Day, Year): AUG 23 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24933 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Roy Cephas
2. DATE OF DEATH (Month, Day, Year): 06 29 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 216-12-1393
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5-26-1915
8. BIRTHPLACE (State or Foreign Country): Maryland
8a. FACILITY NAME (If not institution, give street and number):
9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge
9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Dorchester
10c. CITY, TOWN OR LOCATION: Cambridge
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 436 Oakley St.
10f. ZIP CODE: 21613
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: 1944 1946
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): Secondary — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Minister
16b. KIND OF BUSINESS/INDUSTRY: Church
17. FATHER'S NAME (First, Middle, Last): Ed Brown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Cephas
19a. INFORMANT'S NAME (Type/Print): Emma Cephas
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 436 Oakley St. Cambridge, Md. 21613
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veteran Cemetery
20c. LOCATION — City or Town, State: Hurlock, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bennie L. Smith
22. NAME AND ADDRESS OF FACILITY: Bennie Smith Services, PO Box 928 Hurlock, Md. 21643

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory Arrest	Min.
DUE TO (OR AS A CONSEQUENCE OF): b.	Hyperbilirubinemia	1wk
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Obstructive Jaundice	1mo.
DUE TO (OR AS A CONSEQUENCE OF): d.	Metastatic Adenocarcinoma Stomach	2-3mos

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Metastatic Prostatic Ca

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D10966
29d. DATE SIGNED (Month, Day, Year): ▶ July 10, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 607 Dutchmans Lane Easton Md 21601
31. DATE FILED (Month, Day, Year): JUL 25 '89
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

OHMH-18 Rev 1/89

89 24934

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HARRY ~~Harry~~ JACKSON ~~Jackson~~ NICHOLS ~~Nichols~~

2. DATE OF DEATH Month: Aug. Day: 28, Year: 1989 ~~89~~

3. TIME OF DEATH: 7:30 AM ~~0730~~

4. SOCIAL SECURITY NUMBER: 219-03-4875 ~~219-03-4875~~

5. SEX: 1 ~~MALE~~ F

6. AGE (In yrs. last birthday): 92 YRS.

If under 1 year: Months / Days

If under 24 hrs.: Hours / Min.

7. DATE OF BIRTH (Month, Day, Year): 10/22/96 ~~10/22/96~~

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: FREDERICK

9c. COUNTY OF DEATH: FREDERICK

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: FREDERICK

10c. CITY, TOWN OR LOCATION: WOODSBORO

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO: YES

10e. STREET AND NUMBER: 110 N. MAIN ST.

10f. ZIP CODE: 21798

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed ~~W~~ 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: NO

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: NO

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)

Elementary/Secondary (0-12): 5

College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FACT. WORKER

16b. KIND OF BUSINESS/INDUSTRY: RUBBER CO.

17. FATHER'S NAME (First, Middle, Last): GEORGE F. NICHOLS

18. MOTHER'S NAME (First, Middle, Maiden Surname): MOLLY EYLER

19a. INFORMANT'S NAME (Type/Print): DORAL E. HOFF

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 110 N. MAIN ST. WOODSBORO MD 21798

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BURIAL

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. HOPE CEMETERY

20c. LOCATION — City or Town, State: WOODSBORO, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Catharine O. Hartzler ~~Catharine O. Hartzler~~

22. NAME AND ADDRESS OF FACILITY: D. D. HARTZLER & SONS, WOODSBORO, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

a. Intertrochanteric Fracture

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic heart disease
Cerebral vascular disease
Peripheral vascular disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)

HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Lloyd E. Osburn ~~Lloyd E. Osburn~~

29c. LICENSE NUMBER: M 10514

29d. DATE SIGNED (Month, Day, Year): ▶ 8/18/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lloyd A. Osburn MD 1475 Fancy Gap Rd. Frederick Md

31. DATE FILED (Month, Day, Year): AUG 22 89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall ~~Julia Davidson-Randall~~

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24935

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be detached for use as the burial transit permit.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Leonard Sigfred Olsen
2. DATE OF DEATH (Month, Day, Year): 8 15 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 227-10-5418
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 96 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 5 22 1893
8. BIRTHPLACE (State or Foreign Country): Denmark
9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Frederick
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 606 Apple Ave.
10f. ZIP CODE: 21701
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WW I
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Naval Weapons Station
16b. KIND OF BUSINESS/INDUSTRY: government
17. FATHER'S NAME (First, Middle, Last): Hans Christian Olsen
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rebecca Svendson
19a. INFORMANT'S NAME (Type/Print): Olga R. Wells
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1855 Deer Park Rd., Finksburg, Md. 21048
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶Robert K. Pritts, Sr.
22. NAME AND ADDRESS OF FACILITY: 412 Washington Road, Westminster, Md. 21157

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	- Chronic Obstructive Pulmonary Disease	3y..
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: - Dementia.. - Congestive Heart Failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D 31912
29d. DATE SIGNED (Month, Day, Year): ▶ 8/16/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 516 Third Ave - Frederick, MD 21701 / Same as above
31. DATE FILED (Month, Day, Year): AUG 16 89
32. REGISTRAR'S SIGNATURE: Gloria Burdette-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24936
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Page 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Kenyon Mercer ROBINSON

2. DATE OF DEATH MONTH: 8 DAY: 16 YEAR: 89

3. TIME OF DEATH: 12:11 P M

4. SOCIAL SECURITY NUMBER: 577-32-7595

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 59 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): August 28, 1929

8. BIRTHPLACE (State or Foreign Country): Washington, D.C.

9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Frederick

9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Washington

10c. CITY, TOWN OR LOCATION: Knoxville

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 20012 Brownsville Rd.

10f. ZIP CODE: 21758

10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: Korean Conflict

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 2½

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Contract Co-Ordinator

16b. KIND OF BUSINESS/INDUSTRY: Business Machines

17. FATHER'S NAME (First, Middle, Last): Earl Johnson Robinson

18. MOTHER'S NAME (First, Middle, Maiden Surname): Adelena Willis

19a. INFORMANT'S NAME (Type/Print): Clara E. Robinson

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20012 Brownsville Rd., Knoxville, Md. 21758

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Brownsville Hgts. Cemetery

20c. LOCATION — City or Town, State: Brownsville, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John H. Bast, Jr.

22. NAME AND ADDRESS OF FACILITY: Bast Funeral Home, 7606 Boonsboro Pike, Boonsboro, Md. 21713

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	acute inferoposterior, acute anterolateral myocardial infarction	with
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	cardiogenic shock, complete	
DUE TO (OR AS A CONSEQUENCE OF): c.	heart block, ventricular tachycardia	
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John A. Vitarello M.D.

29c. LICENSE NUMBER: D27544

29d. DATE SIGNED (Month, Day, Year): ▶ 8/16/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): AUG 18 '89

32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24937
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANNIE VERNAL STINE			2. DATE OF DEATH (Month, Day, Year): 08.27 1989	3. TIME OF DEATH: 1200 NOON M
4. SOCIAL SECURITY NUMBER: 215-20-7684	5. SEX: 1 ☐ MALE 2 ☒ FEMALE	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 07/22/23	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 11414 WHISKEY SPRINGS RD.		9b. CITY, TOWN OR LOCATION OF DEATH: WOODSBORO		9c. COUNTY OF DEATH: FREDERICK
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: FREDERICK	10c. CITY, TOWN OR LOCATION: WOODSBORO		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 11414 WHISKEY SPRINGS RD.		10f. ZIP CODE: 21798		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: NO		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SEAMSTRESS	16b. KIND OF BUSINESS/INDUSTRY: SELF-EMPLOY		
17. FATHER'S NAME (First, Middle, Last): EDWARD VERNON SNYDER		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY ELIZABETH PAINE		
19a. INFORMANT'S NAME (Type/Print): JUNE PRICE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9419-B OLD MILL RD. ROCKY RIDGE MD 21778		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BURIAL	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): RESTHAVEN MEMORIAL GARDENS	20c. LOCATION — City or Town, State: NR. FREDERICK, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Catharine D. Hartzler	22. NAME AND ADDRESS OF FACILITY: D. D. HARTZLER & SONS WOODSBORO, MD			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Robert R R Roberts MD	D09867	▶ 08/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 15 West Seventh Street Frederick Md 21701-4599

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 24938

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HARVEY Harvey MARTIN Toms, TOMS, SR.			2. DATE OF DEATH (Month, Day, Year): 08.26.1989		3. TIME OF DEATH: 1155 AM M
4. SOCIAL SECURITY NUMBER: 212-14-7823	5. SEX: 1 MALE F	6. AGE (In yrs. last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 02/06/09	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick, Maryland			9c. COUNTY OF DEATH: Frederick	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: FREDERICK	10c. CITY, TOWN OR LOCATION: FREDERICK	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO: YES
10e. STREET AND NUMBER: 114 E. 8TH ST., APT.3		10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed M 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO: NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☐ NO: NO Specify:	14. RACE — American Indian, Black, White, etc.: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FARMER	16b. KIND OF BUSINESS/INDUSTRY: DAIRY	
17. FATHER'S NAME (First, Middle, Last): JOHN TOMS		18. MOTHER'S NAME (First, Middle, Maiden Surname): DAISY EYLER	
19a. INFORMANT'S NAME (Type/Print): DOROTHY T. TOMS	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 114 E. 8TH ST. FREDERICK MD 21701		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BURIAL	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAK HILL CEMETERY	20c. LOCATION — City or Town, State: LEGORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Catharine O. Hartzler	22. NAME AND ADDRESS OF FACILITY: D. D. HARTZLER & SONS WOODSBORO, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. respiratory arrest
DUE TO (OR AS A CONSEQUENCE OF)

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):

c. Alzheimer's Disease
DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: 03058	29d. DATE SIGNED (Month, Day, Year): 8-26-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gene F. Yoho, 10200 Coppermine Rd. Woodbine, MD 21797

31. DATE FILED (Month, Day, Year): AUG 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davison-Rondeau

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24939
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be detached for use as the burial-transit permit.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John B. Lear		2. DATE OF DEATH (Month, Day, Year): August 24, 1989	3. TIME OF DEATH: 12:35 a.m.
4. SOCIAL SECURITY NUMBER: 219-03-9409	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1/16/18
8. BIRTHPLACE (State or Foreign Country): W.Va			
9a. FACILITY NAME (If not institution, give street and number): Frederick Mem. Hosp.	9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT			
10a. STATE: Md	10b. COUNTY: Carroll ,	10c. CITY, TOWN OR LOCATION: Westminster	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 845 Muller Rd	10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): carpentear	16b. KIND OF BUSINESS/INDUSTRY: Home building
17. FATHER'S NAME (First, Middle, Last): John B. Lear		18. MOTHER'S NAME (First, Middle, Maiden Surname): Edith Kelley Schell	
19a. INFORMANT'S NAME (Type/Print): Sharon Jones		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 845 Muller Rd. Westminster, Md 21157	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Crematory	20c. LOCATION — City or Town, State: Hampstead Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ K. [illegible]		22. NAME AND ADDRESS OF FACILITY: Pritts Funeral Home, Westminster, Md	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEVERE COPD	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PNEUMONIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MANIC-DEPRESSIVE
CHF

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D32171	29d. DATE SIGNED (Month, Day, Year): ▶ 8/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PO Box 328 WALKERSVILLE MD 21793		
31. DATE FILED (Month, Day, Year): AUG 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

VOID DEATH

#89-24940

See Fetal - NICHOLAS R. BROWN

8-17-89 Garrett Co.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24941

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last): Leona Mary Blocher			2. DATE OF DEATH (Month, Day, Year): 8 25 1989	3. TIME OF DEATH: 6:30 a M
4. SOCIAL SECURITY NUMBER: 220-74-9613	5. SEX: 1 M 2 X F	6. AGE (If yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Mar. 19, 1911	8. BIRTHPLACE (State or Foreign Country): Pa.
9a. FACILITY NAME (If not institution, give street and number): Star Route Box 39 D		9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg		9c. COUNTY OF DEATH: Garrett
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Garrett	10c. CITY, TOWN OR LOCATION: Frostburg		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: Star Route, Box 39 D		10f. ZIP CODE: 21532		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 8+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Samuel Weimer			18. MOTHER'S NAME (First, Middle, Maiden Surname): Della Crowe	
19a. INFORMANT'S NAME (Type/Print): George H. Blocher		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Star Route Box 39 D, Frostburg, Md. 21532		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Blocher Cemetery		20c. LOCATION — City or Town, State: Garrett County, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John P. Horn		22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home, Frostburg, Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Ischemic Heart Disease	Months
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Arteriosclerotic Cardio-Vascular Disease	Years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 XX NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 XX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Herbert H. Leighton M.D.	D 05658	▶ August 25, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Herbert H. Leighton, M.D., Oak @ 5th Streets, Oakland, Maryland 21550

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24942
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
MYRON	EUGENE	GRIFFITH	August 15, 1989	4:49 PM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
214-16-2089	1 [X] M 2 [ ] F	65 YRS.			Dec 31, 1923	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Garrett County Memorial Hospital	Oakland	Garrett

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Garrett	Oakland	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
Rt. 5 Box 11	21550	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
0		Never Worked	

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Bert NMI Griffith	Edna NMI Brown

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Ruth McKenzie	Rt. 5 Box 11 Oakland, Maryland 21550

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)	St. John's Cemetery	Accident, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Robert M Hurst M00167	Durst Funeral Home P.O. Box 243 Oakland, Md. 21550

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Massive Cerebrovascular Accident	½ hr
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recent Acute Myocardial Infarction
Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] ND

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] ND	HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined		M	1 [ ] YES 2 [ ] ND	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Karl E. Schwalm	D27205	▶ 8/17/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Karl E. Schwalm, M.D. 311 N. Fourth St. Oakland, Maryland 21550

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 17 '89	Julia Davidson Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24943
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Armand Victor Heckert		2. DATE OF DEATH (Month, Day, Year): 9 / 3 / 89	3. TIME OF DEATH: 222 PM
4. SOCIAL SECURITY NUMBER: 232-58-3267	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 93 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 28, 1896
8. BIRTHPLACE (State or Foreign Country): WV.			
9a. FACILITY NAME (If not institution, give street and number): Dennett Manor Nursing Home	9b. CITY, TOWN OR LOCATION OF DEATH: Oakland	9c. COUNTY OF DEATH: Garrett	

RESIDENCE OF DECEDENT

10a. STATE: WV.	10b. COUNTY: Preston	10c. CITY, TOWN OR LOCATION: Box 57 Eglon,	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: Box 57	10f. ZIP CODE: 26716	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO; IF YES, GIVE WAR OR DATES: WWI	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer	16b. KIND OF BUSINESS/INDUSTRY: Farming	
17. FATHER'S NAME (First, Middle, Last): David Heckert	18. MOTHER'S NAME (First, Middle, Maiden Surname): Celinda Stemple		
19a. INFORMANT'S NAME (Type/Print): Barbara Heckert	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 57 Eglon, WV. 26716		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Texas Cemetery	20c. LOCATION — City or Town, State: Horseshoe Run, WV.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Hinkle Funeral Home Box 186 Davis, WV. 26260		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pulmonary Edema, Acute	1 day
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerotic Cardiovascular Disease	years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): 9/3/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): P.O. Box 8 Eglon WV 26716		
31. DATE FILED (Month, Day, Year): SEP 12 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Rendall	

OHMH-16 Rev 1/89

89 24944

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Billy Duaine Ringer
2. DATE OF DEATH (Month, Day, Year): August 15 1989
3. TIME OF DEATH: 1:45 P. M
4. SOCIAL SECURITY NUMBER: 229-34-6816
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 59 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Dec 18 1929
8. BIRTHPLACE (State or Foreign Country): W.Va.
9a. FACILITY NAME (If not institution, give street and number): Garrett County Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Oakland
9c. COUNTY OF DEATH: Garrett

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Garrett
10c. CITY, TOWN OR LOCATION: Oakland
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Route 5 Box 212
10f. ZIP CODE: 21550
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: Discharged 10-19-48
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: No
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Coal Miner
16b. KIND OF BUSINESS/INDUSTRY: Coal
17. FATHER'S NAME (First, Middle, Last): Ralph Roy Ringer
18. MOTHER'S NAME (First, Middle, Maiden Surname): Hannah Ellen McCabe
19a. INFORMANT'S NAME (Type/Print): Katheryn J. Ringer
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt 5 Box 212 Oakland, MD 21550
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Miller Cemetery
20c. LOCATION — City or Town, State: Terra Alta, W.Va.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Arthur H. Wright
22. NAME AND ADDRESS OF FACILITY: Arthur H. Wright Funeral Home, Inc. 105 Highland Ave. Terra Alta, WV 26764

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Ca lung	4 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	COPD / smoker	4 yrs
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HTN, Alcoholism

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: THP
29c. LICENSE NUMBER: D15333
29d. DATE SIGNED (Month, Day, Year): ▶ 7/22/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas G. Johnson 311 North 4th St. Oakland, MD 21550
31. DATE FILED (Month, Day, Year): AUG 29 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson Randall

DHMH-18 Rev 1/89

89 24945

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GRACIE ELLEN SHREVE				2. DATE OF DEATH (Month, Day, Year): August 21, 1989	3. TIME OF DEATH: 8:40 PM
4. SOCIAL SECURITY NUMBER: 216-74-8439	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 23, 1908	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Dennett Road Manor Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Oakland		9c. COUNTY OF DEATH: Garrett

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Garrett	10c. CITY, TOWN OR LOCATION: Oakland	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 2 Box 240		10f. ZIP CODE: 21550	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Marion Francis Noel		18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Margaret Shreve	
19a. INFORMANT'S NAME (Type/Print): Mrs. Bonnie Harvey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2 Box 287 Oakland, Maryland 21550	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Grove Cemetery	20c. LOCATION — City or Town, State: Gorman, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert M. Durst M00167		22. NAME AND ADDRESS OF FACILITY: P.O. Box 243 Durst Funeral Home - Oakland, Md. 21550	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pneumonia	days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	(apid)	yrs
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alzheimers

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D5333	29d. DATE SIGNED (Month, Day, Year): ▶ 8/22/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas G. Johnson, M.D. 311 N. Fourth St. Oakland, Maryland 21550		
31. DATE FILED (Month, Day, Year): AUG 22 '89	32. REGISTRAR'S SIGNATURE: Gladie Davidson Randall	

DHMH-16 Rev 1/89

89 24946

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Paul L. Anderson (Paul Leonard Anderson)				2. DATE OF DEATH Month: Aug Day: 31, Year: 1989		3. TIME OF DEATH 5 30 PM	
4. SOCIAL SECURITY NUMBER 218-34-6133	5. SEX 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept. 30, 1916		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE Md.	10b. COUNTY Harford	10c. CITY, TOWN OR LOCATION Aberdeen				10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER 1317 N. Stepney Rd.			10f. ZIP CODE 21001		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES WWII	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+) 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lt. Commander (USCoast Guard)		16b. KIND OF BUSINESS/INDUSTRY US-government			
17. FATHER'S NAME (First, Middle, Last) Stephen Haven Anderson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth Leonard			
19a. INFORMANT'S NAME (Type/Print) Mildred K. Anderson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1317 N. Stepney Road, Aberdeen, Md. 21001					
20a. METHOD OF DISPOSITION 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Paul's Lutheran Cemetery		20c. LOCATION — City or Town, State Aberdeen, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Howard K McComas III		22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ARTERIOSCLEROSIS

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER
Senility

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Dante U. Monakil MD	D076424	8/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DANTE U. MONAKIL MD HAVRE de GRACE MD 21078

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 01 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 24947

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY HELENA BEATTIE			2. DATE OF DEATH (Month, Day, Year): August 25 1989	3. TIME OF DEATH: 7:25 a M
4. SOCIAL SECURITY NUMBER: 218-40-1278	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 49 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10/13/1939	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1551 Main Street		9b. CITY, TOWN OR LOCATION OF DEATH: Whiteford		9c. COUNTY OF DEATH: Harford
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Whiteford		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1439 Ridge Road		10f. ZIP CODE: 21160		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Processor		16b. KIND OF BUSINESS/INDUSTRY: Frozen Foods
17. FATHER'S NAME (First, Middle, Last): William J. Beattie		18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine McGreevy		
19a. INFORMANT'S NAME (Type/Print): Georgiana B. Donlin		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1439 Main Street Whiteford, MD 21160		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Slate Ridge Cemetery		20c. LOCATION — City or Town, State: Delta, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeffrey P. Lovelace		22. NAME AND ADDRESS OF FACILITY: Harkins Funeral Home, Inc. Delta, PA		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. LEIOMYOSARCOMA OF UTERUS	14 MON
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: LUNG METASTASES

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D13775	▶ 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joan Edwards, MD 2112 Bel Air Road Fallston, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 20 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 24948

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna Lou Chapman		2. DATE OF DEATH (Month, Day, Year): 8 15 89	3. TIME OF DEATH: 432 PM
4. SOCIAL SECURITY NUMBER: 414-42-3208	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 59 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): April 2, 1930
8. BIRTHPLACE (State or Foreign Country): Tennessee			
9a. FACILITY NAME (If not institution, give street and number): Harford Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace	9c. COUNTY OF DEATH: Harford	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Joppa	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1600 Shirley Avenue	10f. ZIP CODE: 21085	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Seven Years; College (1-4 or 5+): -----	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer	16b. KIND OF BUSINESS/INDUSTRY: Asplundh Tree Company	
17. FATHER'S NAME (First, Middle, Last): Carson Paris White	18. MOTHER'S NAME (First, Middle, Maiden Surname): Isabelle Clark		
19a. INFORMANT'S NAME (Type/Print): Steve Chapman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Port Deposit, Maryland 21904		
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Angel Hill Cemetery	20c. LOCATION — City or Town, State: Havre de Grace, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lee A. Patterson Sr.	22. NAME AND ADDRESS OF FACILITY: Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Resp. Arrest 20 Pul. met.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Multiple Myeloma i Cerebral, Pul, Spinal mets.	
	c. DUE TO (OR AS A CONSEQUENCE OF): associated i Dehydration.	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HTN-ASCVD

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Murli Mathur MD	29c. LICENSE NUMBER: D-14155	29d. DATE SIGNED (Month, Day, Year): 8-16-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Murli Narain Mathur, M.D., 1305 Fallston Rd., Fallston, Maryland

31. DATE FILED (Month, Day, Year): AUG 17 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

4

89 24949

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. pending

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James G. COMBS	2. DATE OF DEATH (Month, Day, Year): 8 31 89	3. TIME OF DEATH: 8:20 A M	
4. SOCIAL SECURITY NUMBER: 215-24-9885	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7 - 12 - 1924	8. BIRTHPLACE (State or Foreign Country): MD		
9a. FACILITY NAME (If not institution, give street and number): 507 Pennington Ave	9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace, Md	9c. COUNTY OF DEATH: HARFORD	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Havre de Grace	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 507 Pennington Avenue	10f. ZIP CODE: 21078	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: Korea	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): (Ret) Laborer	16b. KIND OF BUSINESS/INDUSTRY: Home Improvement Co.	
17. FATHER'S NAME (First, Middle, Last): James R. Combs	18. MOTHER'S NAME (First, Middle, Maiden Surname): Edith V. Scarborough		
19a. INFORMANT'S NAME (Type/Print): Mrs. Myrtle V. Simpers	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29 Grove Street, Aberdeen, MD 21001		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Paul Methodist Cemetery	20c. LOCATION — City or Town, State: Pylesville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William S. Smith	22. NAME AND ADDRESS OF FACILITY: Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertensive & Arteriosclerotic Cardiovascular	
	DUE TO (OR AS A CONSEQUENCE OF): Renal	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard J. Colfer Deputy Medical Examiner	29c. LICENSE NUMBER: DO 1194	29d. DATE SIGNED (Month, Day, Year): ▶ 8/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD J. COLFER, MD. 2013 Tuppe Church Rd. Bellington, MD. 21034		
31. DATE FILED (Month, Day, Year): SEP 01 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

b

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24950

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Taylor Castelow			2. DATE OF DEATH (Month, Day, Year): 8/24/89	3. TIME OF DEATH: 9:30 am M
4. SOCIAL SECURITY NUMBER: 216-14-1654	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9/10/08	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): 11 Calvary Road		9b. CITY, TOWN OR LOCATION OF DEATH: Churchville		9c. COUNTY OF DEATH: Harford
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Churchville		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11 Calvary Road		10f. ZIP CODE: 21028		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4 or 5+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic/part owner		16b. KIND OF BUSINESS/INDUSTRY: Churchville Garage
17. FATHER'S NAME (First, Middle, Last): William D. Castelow			18. MOTHER'S NAME (First, Middle, Maiden Surname): Ellen Amelia Taylor	
19a. INFORMANT'S NAME (Type/Print): Eunice Castelow		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 Calvary Road, Churchville, Md. 21028		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Elkton Cemetery		20c. LOCATION — City or Town, State: Elkton, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kenneth B. Carey		22. NAME AND ADDRESS OF FACILITY: TarringFuneral Home, P.A. Aberdeen, Maryland 21001-3399		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ASCVD	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic Brain Syndrome	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Cachexia. Gastrostomy tube feeding	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. R poliomyelitis	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
▶ F. Lee MD	D20661	8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 28 89	Julia Davidson-Randall

DHMH-16 Rev 1/89

1871

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24951

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gill, Frank Joseph — Frank Joseph Gill
2. DATE OF DEATH: MONTH 08 DAY 22 YEAR 89
3. TIME OF DEATH: 9:30 A M
4. SOCIAL SECURITY NUMBER: 202-10-8686
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10/11/19
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Fallston General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Fallston, Md
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Harford
10c. CITY, TOWN OR LOCATION: Bel Air
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1506 Whistler Road
10f. ZIP CODE: 21014
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII-Korea
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Photographer
16b. KIND OF BUSINESS/INDUSTRY: US-government
17. FATHER'S NAME (First, Middle, Last): John -- Gill
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sophie -- Bogus
19a. INFORMANT'S NAME (Type/Print): Helen D. Gill
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1506 Whistler Road, Bel Air, Md. 21014
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Harford Memorial Gardens,
20c. LOCATION — City or Town, State: Aldino, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III
22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be [illegible] by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be used as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified. If [illegible]

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, euch es cerdiec or respiretory arreet, ehock, or heert failure. Liet only one cause on eech line.

		Approximate Interval Between Oneet end Death
IMMEDIATE CAUSE (Finel disease or condition reeulting in death) →	a. Acute myocardial infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentielly liet conditions, if eny, leeding to immediete ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initieted evente reeulting in death) LAST	b. Pulmonary Edema	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuee given in Part I.: End Stage Renal Failure; Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Andrew Nowakowski MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 8/23/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANDREW NOWAKOWSKI MD 125 N. MAIN ST BEL AIR, MD
31. DATE FILED (Month, Day, Year): AUG 23 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-18 Rev 1/89

89 24952

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Catherine E. Gildea			2. DATE OF DEATH: MONTH 8 DAY 25 YEAR 89	3. TIME OF DEATH: 1:45 A M
4. SOCIAL SECURITY NUMBER: 218-22-0746	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4/3/05	8. BIRTHPLACE (State or Foreign Country): N.J.
9a. FACILITY NAME (If not institution, give street and number): Harford Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Harre de Grace	9c. COUNTY OF DEATH: Harford	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Aberdeen	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 222 Custis St.		10f. ZIP CODE: 21001	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Civil Servant	16b. KIND OF BUSINESS/INDUSTRY: U.S. Govt.
17. FATHER'S NAME (First, Middle, Last): John F. Gildea, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Moran	
19a. INFORMANT'S NAME (Type/Print): William J. Gildea, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5904 Cobalt Road, Bethesda, Md. 20816	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery	20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert M. Carver		22. NAME AND ADDRESS OF FACILITY: Tarring Funeral Home, P.A. Aberdeen, Md. 21001-3399	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Acute Pulmonary Insufficiency
DUE TO (OR AS A CONSEQUENCE OF):
c. S/P Cardiopulmonary Arrest 2° to Cerebrovascular Accident
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

couple of weeks

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ASHD, Hx of Acute MI
Gastrointestinal Bleeding

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D19583	29d. DATE SIGNED (Month, Day, Year): ▶ 8/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LAZATIN, MANUEL Bel Air, Md		
31. DATE FILED (Month, Day, Year): AUG 20 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

20+1

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24953
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be attached to the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Henry Vernon Haskell			2. DATE OF DEATH (Month, Day, Year): 8-19-89	3. TIME OF DEATH: 9:14PM M
4. SOCIAL SECURITY NUMBER: 127-03-5313	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 3,1918	8. BIRTHPLACE (State or Foreign Country): Maine
9a. FACILITY NAME (If not institution, give street and number): Fallston General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Fallston	9c. COUNTY OF DEATH: Harford County	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Edgewood	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2405 Sycamore Lane		10f. ZIP CODE: 21040	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII, Vietnam	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Warrant Officer	16b. KIND OF BUSINESS/INDUSTRY: US-Military
17. FATHER'S NAME (First, Middle, Last): Vernon -- Haskell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Jennie E. Eaton	
19a. INFORMANT'S NAME (Type/Print): Rosalie H. Haskell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2405 Sycamore Lane, Edgewood,Md. 21040	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Memorial Gardens	20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III		22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon,Md. 21009	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Julia C. Goodin M.D.	OCME	▶ 8-20-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin,M.D. 111 Penn Street,Baltimore,Maryland 21201 vc

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 22 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 24954

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charlie (nmn) King / Charles, KING			2. DATE OF DEATH: Month 8, Day 26, Year 89	3. TIME OF DEATH: 4:59 PM
4. SOCIAL SECURITY NUMBER: 218-28-4489	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 57 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): 4-14-32	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): FALLSTON GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: FALLSTON, Md.		9c. COUNTY OF DEATH: HARFORD
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Bel Air		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 2021 Ruffs Mill Rd.		10f. ZIP CODE: 21014		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 3 — College (1-4 or 5+):	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Handicapped (never worked)	16b. KIND OF BUSINESS/INDUSTRY: Not applicable		
17. FATHER'S NAME (First, Middle, Last): Joseph - King		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mae -- Billings		
19a. INFORMANT'S NAME (Type/Print): Luella K. Thomas		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2013 Ruffs Mill Road, Bel Air, Md. 21014		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bel Air Memorial Gardens,	20c. LOCATION — City or Town, State: Bel Air, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III		22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or reapiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a.	Congestive heart failure	10d.
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST — b.	Acute myocardial infarction	10d.
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Severe C.A.D	
DUE TO (OR AS A CONSEQUENCE OF):		
d.	HTN, Diabetes, high cholesterol	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Scott A. Haswell		▶ 8/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): & Scott S. Haswell, 620 Boulton St, Bel Air MD 21014

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 28 '89	Julia Davidson Randall

DHMH-16 Rev 1/89

89 24955

12+1

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Holland S. Otis			2. DATE OF DEATH (Month / Day / Year): Aug 21 89	3. TIME OF DEATH: 9:16 P M
4. SOCIAL SECURITY NUMBER: 122 12 4853	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 06-17-1914	8. BIRTHPLACE (State or Foreign Country): MASS
9a. FACILITY NAME (If not institution, give street and number): HARFORD MEMORIAL Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: HAVRE DE GRACE		9c. COUNTY OF DEATH: HARFORD
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Havre de Grace		10d. INSIDE CITY LIMITS? [X] 1 YES 2 [ ] NO
10e. STREET AND NUMBER: 303 Commerce Street		10f. ZIP CODE: 21078		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1962-1982	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): (Ret) Master Sgt.	16b. KIND OF BUSINESS/INDUSTRY: U.S. Army		
17. FATHER'S NAME (First, Middle, Last): James M. Otis		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie C. Holland		
19a. INFORMANT'S NAME (Type/Print): Mrs. Oda E. Otis	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 303 Commerce Street, Havre de Grace, MD 21078			
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State [ ] 4 Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Angel Hill Cemetery	20c. LOCATION — City or Town, State: Havre de Grace, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William S Smith	22. NAME AND ADDRESS OF FACILITY: Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	metastatic Ca. of the liver	> 1 month.
DUE TO (OR AS A CONSEQUENCE OF): b.	Adenocarcinoma of left lung	3 months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	& pleural effusion.	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: A.S.C.V.D.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edward C. Loomis	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 8/21/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): EDWARD C. Loomis, M.D. Havre de Grace, Md. 21078.		
31. DATE FILED (Month, Day, Year): AUG 22 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 24956

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
John W. Patterson Jr	8 / 25 / 89	6:23 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
219-18-7690	1 [X] M 2 [ ] F	63 YRS.			10 7 25	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Harford Memorial Hospital	Havre de Grace	Harford

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Cecil	Perryville	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WNAT COUNTRY?
540 Arch Street	21903	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	[X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: W.W. II	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
Twelve Years	----	Bookkeeper	T & E International Bel Air, Maryland

17. FATNER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
John W. Patterson, Sr.	Emma Boyd

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ruby Anderson Patterson	540 Arch St., Perryville, Md. 21903

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	St. Mark's Cemetery	Perryville, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Ron. J. Patterson, Sr.	Lee A. Patterson & Son Funeral Home Perryville, Maryland

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Intracerebellar Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Richard J. Colfer MD Deputy Medical Examiner	DO 1194	▶ 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
RICHARD J. COLFER, MD 2013 Tuttle Church Road Darlington, Md. 21034	AUG 28 '89	Julia Davidson-Randall

DHMH-18 Rev 1/89

12 +1 grates.

10

89 24957

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Grover Brown Sexton / GROVER, BROWN, SEXTON		2. DATE OF DEATH (Month, Day, Year) 8 29 Aug 29, '89	3. TIME OF DEATH 952 PM
4. SOCIAL SECURITY NUMBER 224-24-4893	5. SEX 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday) 67 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year) May 30, 1922
8. BIRTHPLACE (State or Foreign Country) Wytheville, Virginia			
9a. FACILITY NAME (If not institution, give street and number) Fallston Gen Hosp / FALLSTON GENERAL HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH Fallston / FALLSTON	9c. COUNTY OF DEATH Harford / HARFORD	

RESIDENCE OF DECEDENT

10a. STATE Maryland	10b. COUNTY Harford	10c. CITY, TOWN OR LOCATION Fallston	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER 2208 Fallston Road	10f. ZIP CODE 21047	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 6 / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Heavy Equipment Operator	16b. KIND OF BUSINESS/INDUSTRY Stone Quarry	
17. FATHER'S NAME (First, Middle, Last) Mitchell Walker Sexton	18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Mae Crouse		
19a. INFORMANT'S NAME (Type/Print) Wife 877-1783 Mrs. Irene M Sexton	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2208 Fallston Road, Fallston, Maryland 21047		
20a. METHOD OF DISPOSITION [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Bel Air Memorial Gardens	20c. LOCATION — City or Town, State Bel Air, Md. 21014	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph W. Foster / Joseph W. Foster	22. NAME AND ADDRESS OF FACILITY Foster Funeral Home 50 W. Broadway & Williams St. Bel Air, Maryland 21014		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac Arrest	
DUE TO (OR AS A CONSEQUENCE OF): b.	Severe CAD	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	ASCVD	
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular dis

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER D-16444	29d. DATE SIGNED (Month, Day, Year) 8/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) V.S. Nair MD - 2112 Bellair Road - Fallston MD		
31. DATE FILED (Month, Day, Year) AUG 30 '89	32. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24958 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Viola L. Wyatt
2. DATE OF DEATH: MONTH 8 DAY 27 YEAR 89
3. TIME OF DEATH: 4 20 A M
4. SOCIAL SECURITY NUMBER: 213-28-6988
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 56 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5-30-33
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Harford Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Cecil
10c. CITY, TOWN OR LOCATION: Perryville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Lot No. 3 Wagon Wheel Trailer Park
10f. ZIP CODE: 21903
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Eight Years — College (1-4 or 5+): ------
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: -----
17. FATHER'S NAME (First, Middle, Last): Harvey Keyes, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Cora Madeline Meads
19a. INFORMANT'S NAME (Type/Print): Richard E. Wyatt
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 36 Peacock Lane, Port Deposit, Md. 21904
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Angel Hill Cemetery
20c. LOCATION — City or Town, State: Havre de Grace, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald J. Patterson, Sr.
22. NAME AND ADDRESS OF FACILITY: Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY:
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Richard J. Colfer MD Deputy Examiner
29c. LICENSE NUMBER: DO 1194
29d. DATE SIGNED (Month, Day, Year): 8/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD J. COLFER, MD 2013 Taffy Church Road Darlington, Md 21034
31. DATE FILED (Month, Day, Year): AUG 28 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

6

10

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24959
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elva L. Wilson
2. DATE OF DEATH (Month, Day, Year): Aug 28, 1989
3. TIME OF DEATH: 6:17 A M
4. SOCIAL SECURITY NUMBER: 220 09 6136
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 95 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 08-19-1894
8. BIRTHPLACE (State or Foreign Country): MD

9a. FACILITY NAME (If not institution, give street and number): Harford Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Harford
10c. CITY, TOWN OR LOCATION: Havre de Grace
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 123 North Stokes Street
10f. ZIP CODE: 21078
10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 1
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): (Ret) Accounting Clerk
16b. KIND OF BUSINESS/INDUSTRY: Federal Government

17. FATHER'S NAME (First, Middle, Last): Charles H. Trimble
18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Carr

19a. INFORMANT'S NAME (Type/Print): Mrs. Patricia W. McMullan
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 607 South Washington St., Havre de Grace, MD 21078

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Wesleyan Chapel Cemetery
20c. LOCATION — City or Town, State: Aberdeen, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William S. Smith II
22. NAME AND ADDRESS OF FACILITY: Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	(1) a. Congestive Heart Failure & Pleural effusion	5 days
	DUE TO (OR AS A CONSEQUENCE OF): b. A.S.C.V.D.	5 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): (2) c. Intestinal Obstruction due to	
	DUE TO (OR AS A CONSEQUENCE OF): d. recurrent + metastatic Ca. of Colon.	'89.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
(1) Chronic Brain Syndrome due to Senility
(2) C.O.P.D. & Senile Emphysema
(3) Iron Deficiency Anemia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number; City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: E. Coon, M.D.
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 8/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E. Coon, M.D. 319 S. Union Ave. Havre de Grace, Md. 21078

31. DATE FILED (Month, Day, Year): AUG 29 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24960 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gladys Lurray Cole
2. DATE OF DEATH (Month, Day, Year): August 14, 1989
3. TIME OF DEATH: 10:30 A M
4. SOCIAL SECURITY NUMBER: 21910 0497
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Oct. 26, 1919
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 9040 Washington street
9b. CITY, TOWN OR LOCATION OF DEATH: Savage, Maryland
9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Howard
10c. CITY, TOWN OR LOCATION: Savage
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9040 Washington Street
10f. ZIP CODE: 20763
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 11 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): William Lilley
18. MOTHER'S NAME (First, Middle, Maiden Surname): Laura V. Adrean
19a. INFORMANT'S NAME (Type/Print): Cheryl Hiett
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9040 a Washington Street Savage, Maryland 20763
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Savage Cemetery
20c. LOCATION — City or Town, State: Savage, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donaldson, Jr.
22. NAME AND ADDRESS OF FACILITY: Donaldson Funeral Home, Laurel, Md

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pneumonia	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Carcinoma Tonsils	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Bronchogenic Carcinoma	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: William A Ware
29c. LICENSE NUMBER: MD13916
29d. DATE SIGNED (Month, Day, Year): ▶ 8/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Wm A Ware MD 321 Prince George St Laurel, Md 20707
31. DATE FILED (Month, Day, Year): AUG 18 '89
32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

DHMH-16 Rev 1/89

Items 1,4,8,15,18 Film G655 9-15-89 W.H. Per F/H

89 24961

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James ~~R Fanning~~ Burton Fanning

2. DATE OF DEATH: MONTH 8 DAY 8 YEAR 89

3. TIME OF DEATH: 2:40 P M

4. SOCIAL SECURITY NUMBER: 460-03-~~0690~~ 4340

5. SEX: 1 ☐ M 2 ☐ F — X

6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 9-10-07

8. BIRTHPLACE (State or Foreign Country): ~~US~~ Miss

9a. FACILITY NAME (If not institution, give street and number): 9438 MACOMBER LANE

9b. CITY, TOWN OR LOCATION OF DEATH: COLUMBIA

9c. COUNTY OF DEATH: HOWARD

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: HOWARD

10c. CITY, TOWN OR LOCATION: COLUMBIA

10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO

10e. STREET AND NUMBER: 9438 MACOMBER LANE

10f. ZIP CODE: 21045

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+): UNKNOWN

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SELF-EMPLOYED

16b. KIND OF BUSINESS/INDUSTRY: OIL FIELD EQUIPMENT

17. FATHER'S NAME (First, Middle, Last): BRANTLEY FANNING

18. MOTHER'S NAME (First, Middle, Maiden Surname): ~~LANEY~~ Lanie Pearl James ~~PEARL~~

19a. INFORMANT'S NAME (Type/Print): PATRICIA FANNING

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9438 MACOMBER LANE, COLUMBIA, MD 21045

20a. METNOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE-WASHINGTON CREM.

20c. LOCATION — City or Town, State: LAUREL, MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: moo535

22. NAME AND ADDRESS OF FACILITY: SLACK FUNERAL HOME, ELLICOTT CITY, MARYLAND 21043

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic carcinoma

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William Flowers

29c. LICENSE NUMBER: D20708

29d. DATE SIGNED (Month, Day, Year): 8/9/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William Flowers, M.D. 11055 Little Patuxent Pkwy Columbia Md. 21044

31. DATE FILED (Month, Day, Year): AUG 15 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24962 REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen Elizabeth Gerwig
2. DATE OF DEATH (Month, Day, Year): August 28, 1989
3. TIME OF DEATH: 1:30 am M
4. SOCIAL SECURITY NUMBER: 213 - 22 - 0900
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 63 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): November 18, 1925
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 12865 Linden Church Road
9b. CITY, TOWN OR LOCATION OF DEATH: Clarksville
9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Howard
10c. CITY, TOWN OR LOCATION: Clarksville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 12865 Linden Church Road
10f. ZIP CODE: 21029
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 11 College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): linotype operator
16b. KIND OF BUSINESS/INDUSTRY: U S government
17. FATHER'S NAME (First, Middle, Last): Henry Wadsworth Wehland
18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Pearson
19a. INFORMANT'S NAME (Type/Print): Herman L. Gerwig
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12865 Linden Church Road, Clarksville, Md 21029
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Christ Church Cemeteery
20c. LOCATION — City or Town, State: Columbia, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donaldson
22. NAME AND ADDRESS OF FACILITY: Donaldson Funeral Home, Laurel, Md

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Metastatic Breast Cancer	4 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Inflammatory skin + bone mets

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Donald E. Dillon MD
29c. LICENSE NUMBER: D13832
29d. DATE SIGNED (Month, Day, Year): 28 Aug 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Donald E. Dillon, MD 2901 Olney-Sandy Spring Road, Olney, Md
31. DATE FILED (Month, Day, Year): AUG 30 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson Rhodes

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 24963

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LEONARD LEON JONES		2. DATE OF DEATH (Month, Day, Year): 8 - 8 - 89	3. TIME OF DEATH: 12:40 P.M
4. SOCIAL SECURITY NUMBER: 702-12-7897	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 73 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 11-23-1915
8. BIRTHPLACE (State or Foreign Country): MISSOURI			
9a. FACILITY NAME (If not institution, give street and number): 8670 RIDGE ROAD	9b. CITY, TOWN OR LOCATION OF DEATH: ELLICOTT CITY	9c. COUNTY OF DEATH: HOWARD	
RESIDENCE OF DECEDENT			
10a. STATE: MARYLAND	10b. COUNTY: HOWARD	10c. CITY, TOWN OR LOCATION: ELLICOTT CITY	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 8670 RIDGE ROAD	10f. ZIP CODE: 21043	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CARPENTRY	16b. KIND OF BUSINESS/INDUSTRY: HAROLD E. JONES CONST.	
17. FATHER'S NAME (First, Middle, Last): VOLLIE JONES	18. MOTHER'S NAME (First, Middle, Maiden Surname): IMOGENE WHITE		
19a. INFORMANT'S NAME (Type/Print): LENNY L. JONES	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6608 FORTNIGHT CT., COLUMBIA, MD 21044		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CRESTLAWN MEMORIAL GDNS.	20c. LOCATION — City or Town, State: MARRIOTTSVILLE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John Dallas Slack	22. NAME AND ADDRESS OF FACILITY: SLACK FUNERAL HOME M00535 ELLICOTT CITY, MARYLAND 21043		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicstions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardio-vascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

		24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas F. Herbert MD	29c. LICENSE NUMBER: D-5002	29d. DATE SIGNED (Month, Day, Year): ▶ 8-8-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas F. Herbert MD 3545 Ellicott Mills Dr. Ellicott City, MD 21043

31. DATE FILED (Month, Day, Year): AUG 15 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24964

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lillian LECHNER			2. DATE OF DEATH: MONTH 08 DAY 23 YEAR 89	3. TIME OF DEATH: 0730 AM
4. SOCIAL SECURITY NUMBER: 218225611	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12/02/27	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Howard County Gen. Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Columbia, Md	9c. COUNTY OF DEATH: Howard	
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Columbia	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 6200 Foreland Garth		10f. ZIP CODE: 21045	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager & Owner	16b. KIND OF BUSINESS/INDUSTRY: Sun Valley Motel		
17. FATNER'S NAME (First, Middle, Last): Delbert J. Kelley		18. MOTNER'S NAME (First, Middle, Maiden Surname): Gladys M. Oates		
19a. INFORMANT'S NAME (Type/Print): Frank P. Lechner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6200 I Foreland Garth Columbia, Maryland 21045		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Cemetery	20c. LOCATION — City or Town, State: Elkridge, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry H. Witzke	22. NAME AND ADDRESS OF FACILITY: HARRY H. WITZKE FUNERAL HOME 4112 Columbia Rd., Ellicott City, Md. 21043			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Insufficiency DUE TO (OR AS A CONSEQUENCE OF):	2 months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Metastatic Uterine Cancer DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Steven W. Greer MA Attending	MD D34868	▶ 8-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Steve Greer 11055 Little Patuxent Parkway, Columbia, MD 21044

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 24 89	Gena Davidson-Randall

DHMH-16 Rev 1/88

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24965
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Albert . R . LAVERDIERE
2. DATE OF DEATH: MONTH 08 DAY 17 YEAR 1989
3. TIME OF DEATH: 4-25 A M
4. SOCIAL SECURITY NUMBER: 037-10-5977
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 04-19-1919
8. BIRTHPLACE (State or Foreign Country): Rhode Island
9a. FACILITY NAME (If not institution, give street and number): Howard County General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: COLUMBIA.
9c. COUNTY OF DEATH: HOWARD

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Howard
10c. CITY, TOWN OR LOCATION: Ellicott City
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3521 N. Chatham Road
10f. ZIP CODE: 21043
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Treasury Dept.
16b. KIND OF BUSINESS/INDUSTRY: U.S. Government
17. FATHER'S NAME (First, Middle, Last): Charles Laverdiere
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosalie Pariseau
19a. INFORMANT'S NAME (Type/Print): Mary J. Laverdiere
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3521 N. Chatham Rd.,Ellicott City,Md., 21043
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crestlawn Cemetery
20c. LOCATION — City or Town, State: Marriottsville,Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry H. Witzke
22. NAME AND ADDRESS OF FACILITY: HARRY H. WITZKE FUNERAL HOME 4112 Columbia Rd.,Ellicott City,Md.21043

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CONGESTIVE CARDIAC FAILURE	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	HEPATO - RENAL FAILURE	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	ALCOHOLIC LIVER (CIRRHOSIS) DISEASE	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) / 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: N.B. Vellanki
29c. LICENSE NUMBER: D.30469
29d. DATE SIGNED (Month, Day, Year): ▶ 8/17/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): N.B.VELLANKI, MD; 9055, CHEVROLET DRIVE #101; ELLICOTT CITY, MD. 21043.
31. DATE FILED (Month, Day, Year): AUG 22 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 24966

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Phillip Paris				2. DATE OF DEATH: Month 08, Day 12, Year 89	3. TIME OF DEATH: 7 45 P M
4. SOCIAL SECURITY NUMBER: 218-28-8257	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 05/28/33	8. BIRTHPLACE (State or Foreign Country): Va.
9a. FACILITY NAME (If not institution, give street and number): Bon Secours Extended Care Facility			9b. CITY, TOWN OR LOCATION OF DEATH: Ellicott City, Md.		9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Ellicott City	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3337 Coventry Dr.	10f. ZIP CODE: 21043	10g. CITIZEN OF WHAT COUNTRY? USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unk. College (1-4 or 5+): unk.	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer	16b. KIND OF BUSINESS/INDUSTRY: Fairchild	
17. FATHER'S NAME (First, Middle, Last): Athey Paris	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruby Cheatham		
19a. INFORMANT'S NAME (Type/Print): Ethel Paris	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3337 Coventry Dr. Ellicott City, Md. 21043		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Balt. Wash. Crematory	20c. LOCATION — City or Town, State: Laurel, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] MD535	22. NAME AND ADDRESS OF FACILITY: Slack Funeral Home, PO Box 268, Ellicott City, Md. 21043		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Carcinoma of Lung	yrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
B.H. Minchew, M.D.		▶ 8/12/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): B.H. Minchew 2850 N. Ridge Rd; Ellicott City, Md. 21043

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 15 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24967
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edith Maria Ways			2. DATE OF DEATH (Month, Day, Year): 9 3 89	3. TIME OF DEATH: 937 P M
4. SOCIAL SECURITY NUMBER: 217-48-9739	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Nov 21 1897
8. BIRTHPLACE (State or Foreign Country): MARYLAND				
9a. FACILITY NAME (If not institution, give street and number): HOWARD CO. GENERAL HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: Columbia Md.	9c. COUNTY OF DEATH: Howard Co.		

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: HOWARD	10c. CITY, TOWN OR LOCATION: COLUMBIA	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 9481 CAMEL DRIVER COURT	10f. ZIP CODE: 21045	10g. CITIZEN OF WHAT COUNTRY?: uU. S. A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: HOUSEWIFE	
17. FATHER'S NAME (First, Middle, Last): WILLIAM ALMOND	18. MOTHER'S NAME (First, Middle, Maiden Surname): BERTHA JUDY		
19a. INFORMANT'S NAME (Type/Print): KAREN LEASE	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9481 CAMEL DRIVER COURT COLUMBIA, MARYLAND 21045		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ROSEHILL CEMETERY	20c. LOCATION — City or Town, State: CUMBERLAND MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dale L. Merritt	22. NAME AND ADDRESS OF FACILITY: SILCOX-MERRITT FUNERAL HOME 404 DECATUR ST. CUMBERLAND MARYLAND 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis d/t shock DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: C.I Blood

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D22587	29d. DATE SIGNED (Month, Day, Year) ▶ 9/5/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gary Fridkin 1055 Little Patuxent Pkwy Col. Md.		
31. DATE FILED (Month, Day, Year): SEP 05 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

4

596-6898

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24968 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James B. WIESE			2. DATE OF DEATH (Month - Day - Year): 8 - 25 - 89	3. TIME OF DEATH: 6:00 PM
4. SOCIAL SECURITY NUMBER: 466-86-6153	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 25 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 012264	8. BIRTHPLACE (State or Foreign Country): Texas
9a. FACILITY NAME (If not institution, give street and number): 3430 Coventry Court		9b. CITY, TOWN OR LOCATION OF DEATH: Ellicott City, Md		9c. COUNTY OF DEATH: Howard
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: HOWARD	10c. CITY, TOWN OR LOCATION: Ellicott City		10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 3430 Coventry Court		10f. ZIP CODE: 21043		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES: 1982-1986	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mailman	16b. KIND OF BUSINESS/INDUSTRY: Postal Service		
17. FATHER'S NAME (First, Middle, Last): Sherrell James Wiese		18. MOTHER'S NAME (First, Middle, Maiden Surname): Carlene Jo Newland		
19a. INFORMANT'S NAME (Type/Print): Carlene Jo Newland	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5491 Marsh Hawk Way Columbia Md 21045			
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest	20c. LOCATION — City or Town, State: Owings Mills MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry H. Witzke	22. NAME AND ADDRESS OF FACILITY: Harry H Witzke Funeral Home 4112 Columbia Pike Ellicott City Md 21043			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Gunshot Wound, head
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? X YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 X Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 8-25-89

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 X NO

28d. DESCRIBE HOW INJURY OCCURED: Shot self in head

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 3430 Coventry Ct. Ellicott City MD

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
T. F. Herbert MD Deputy Medical Examiner	D-5002	▶ 8-25-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): T.F. Herbert M.D. 3525 Ellicott Mills Dr. Ellicott City, MD 21043

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 28 '89	Julia Davidson-Randall

6

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24969
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~Gaxxx~~ Garry Roger Bailey, Sr.

2. DATE OF DEATH (Month, Day, Year): 8-19-89

3. TIME OF DEATH: 7:05AM M

4. SOCIAL SECURITY NUMBER: 236 72 8547

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 42 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): June 6,1947

8. BIRTHPLACE (State or Foreign Country): West Virginia

9a. FACILITY NAME (If not institution, give street and number): Kent & Queen Anne Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown

9c. COUNTY OF DEATH: Kent County

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Kent

10c. CITY, TOWN OR LOCATION: Chestertown

10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 207 Washington Ave.

10f. ZIP CODE: 21620

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: Married
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify: No

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): Grade 10
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): printer

16b. KIND OF BUSINESS/INDUSTRY: Campbell Printing Co

17. FATHER'S NAME (First, Middle, Last): Nathan Harold Bailey

18. MOTHER'S NAME (First, Middle, Maiden Surname): Murlene Miller

19a. INFORMANT'S NAME (Type/Print): Doris Bailey

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 207 Washington Avenue, Chestertown, Maryland 21620

20a. METHOD OF DISPOSITION
[X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State
4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parklawn Cemetery

20c. LOCATION — City or Town, State: Rockville, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Louise Donaldson

22. NAME AND ADDRESS OF FACILITY: Donaldson Funeral Home P.A.
313 Talbott Ave. Laurel, Md. 20707

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Hypertensive heart disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Seizure disorder

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

26d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): ▶ 8-19-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Mo., Day, Year): AUG 24 1989
AUG 24 '89

32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randell
Gloria Davidson-Randell

5

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24970

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NANCY VIRGINIA HICKMAN / NANCY VIRGINIA HICKMAN			2. DATE OF DEATH: MONTH 08 DAY 31 YEAR 89	3. TIME OF DEATH: 7:14 PM
4. SOCIAL SECURITY NUMBER: 217 42 6026	5. SEX: 1 ☐ M 2 ☐ F XX Female	6. AGE (In yrs. last birthday): ~~45~~ 45 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10-26-43
8. BIRTHPLACE (State or Foreign Country): Q.A. CO. Maryland				
9a. FACILITY NAME (If not institution, give street and number): KENT & QUEEN ANNE'S HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown	9c. COUNTY OF DEATH: Kent		

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Queen Anne	10c. CITY, TOWN OR LOCATION: RFD Chestertown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: RFD # 1 Box # 364	10f. ZIP CODE: 21620	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed XX ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO; IF YES, GIVE WAR OR DATES: No	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: No	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dietitian (Cafeteria)	16b. KIND OF BUSINESS/INDUSTRY: Hospital	
17. FATHER'S NAME (First, Middle, Last): Floyd Crew	18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara States		
19a. INFORMANT'S NAME (Type/Print): Floyd Crew	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rte # 1 Box # 364 Chestertown, Md. 21620		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BURIAL	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crumpton Cemetery (Sept. 3, 1989)	20c. LOCATION — City or Town, State: Crumpton, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. Willis Wells	22. NAME AND ADDRESS OF FACILITY: J. Willis Wells P.O. Box # 164 Chestertown, Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Brain Metastases	2-3 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Lung Carcinoma	1 yr.
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M.D.	29c. LICENSE NUMBER: D 20840	29d. DATE SIGNED (Month, Day, Year): 8/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael Bey Chestertown, Md. 21620		
31. DATE FILED (Month, Day, Year): SEP 1 89	32. REGISTRAR'S SIGNATURE: Jacha Davidson-Randall	

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24971
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ethel Elizabeth Robinson				2. DATE OF DEATH (Month, Day, Year): Aug. 7, 1989	3. TIME OF DEATH: 11.00 AM
4. SOCIAL SECURITY NUMBER: YES	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2-16-1921	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): At Home			9b. CITY, TOWN OR LOCATION OF DEATH: R.F.D.#3 Chestertown		9c. COUNTY OF DEATH: Kent

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Kent	10c. CITY, TOWN OR LOCATION: Chestertown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: R.F.D.#3	10f. ZIP CODE: 21620		10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Secondary; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Labor	16b. KIND OF BUSINESS/INDUSTRY: Various	
17. FATHER'S NAME (First, Middle, Last): Robert Robinson SR.	18. MOTHER'S NAME (First, Middle, Maiden Surname):		
19a. INFORMANT'S NAME (Type/Print): Miss. Diane Robinson	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R.F.D.#3 Box 51 Chestertown, Md. 21620		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Janes United Meth. Cem.	20c. LOCATION — City or Town, State: Chestertown	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: WALLEY'S FUNERAL HOME, Chestertown, Maryland 21620		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ca of Breast with Bone & Lung Metastasis DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D21313	▶ 8/11/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kin K. Wun, 216 High St, Chestertown, Md. 21620

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 21 '89	Julia Davidson-Randall

2

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24972 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Milford Todd Sr.
2. DATE OF DEATH (Month, Day, Year): 8 25 1989
3. TIME OF DEATH: 4:20 A M
4. SOCIAL SECURITY NUMBER: 213 03 0011
5. SEX: 1 [X] M 2 [ ] F — Male
6. AGE (In yrs. last birthday): 85 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): Mar 3, 1904
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): The Kent & Queen Anne's Hospital Inc.
9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown
9c. COUNTY OF DEATH: Kent

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Kent
10c. CITY, TOWN OR LOCATION: Chestertown
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: P.O. Box # 297 Langford Bay Estates
10f. ZIP CODE: 21620
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced — Married
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES: XX
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: No
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Furniture Store Owner
16b. KIND OF BUSINESS/INDUSTRY: Retail Furniture
17. FATHER'S NAME (First, Middle, Last): James Thomas Todd
18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Thomas
19a. INFORMANT'S NAME (Type/Print): James Milford Todd, Jr.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box # 297 Chestertown, Md. 21620
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) — Burial
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dorchester Memorial Cemetery
20c. LOCATION — City or Town, State: near Cambridge, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. Willis Wells
22. NAME AND ADDRESS OF FACILITY: J. Willis Wells — P.O. Box # 264 Chestertown, Md. 21620

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ① Pleural Effusion ② Ascites ③ Congestive Heart Failure ④ Arteriosclerotic Heart disease ⑤ Chronic Atrial Fibrillation ⑥ Normotensive Hydrocephalus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: K. William, MD.
29c. LICENSE NUMBER: D 21313
29d. DATE SIGNED (Month, Day, Year): 8/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KEN K. WILLIAM, 216 High St, Chestertown, Md. 21620
31. DATE FILED (Month, Day, Year): AUG 25 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

10

DHMH-16 Rev 1/89

Items:23,27 per ME G-655 9-22-89 cm

89 24973

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1; 2; 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Doris F. Akinfe			2. DATE OF DEATH (Month, Day, Year): 8-17-89	3. TIME OF DEATH: 9:56PM M
4. SOCIAL SECURITY NUMBER: 577-82-8608	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 44 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12/25/44	8. BIRTHPLACE (State or Foreign Country): Nigeria
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery County

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Adelphi, Maryland	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2212 Phelps Road		10f. ZIP CODE: 20783	10g. CITIZEN OF WHAT COUNTRY?: Nigeria

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1/12; College (1-4 or 5+): Business	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Medical Assistant	16b. KIND OF BUSINESS/INDUSTRY: Nursing Agency	
17. FATHER'S NAME (First, Middle, Last): David Akinbobola		18. MOTHER'S NAME (First, Middle, Maiden Surname): Olatundun Adefowoju	
19a. INFORMANT'S NAME (Type/Print): Gbenga Akinfe	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2212 Phelps Road Adelphi, Md. 20783		
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): George Washington Cemetery	20c. LOCATION — City or Town, State: Adelphi, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael J. Rinaldi	22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 New Hamp. Ave. S.S.Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute alcohol intoxication

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Fatty Liver

24a. WAS AN AUTOPSY PERFORMED? ☒ 1 YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ 1 YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ 1 YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient ☒ 2 ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 8-17-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,M.D. 111 Penn Street,Baltimore,MD 21201		VC
31. DATE FILED (Month, Day, Year): AUG 25'89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

10

89 24974

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HERMAN L. ABRAHMS			2. DATE OF DEATH (Month/Day/Year): 08/23/89	3. TIME OF DEATH: 2:40 P.M.
4. SOCIAL SECURITY NUMBER: 156-30-6393	5. SEX: XX M 2 ☐ F	6. AGE (In yrs. last birthday): 96 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 25, 1892	8. BIRTHPLACE (State or Foreign Country): Rhode Island
9a. FACILITY NAME (If not institution, give street and number): Hebrew Home of Gtr. Washington		9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 6121 Montrose Road		10f. ZIP CODE: 20852	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XX 1 YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WWI	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sign Painter	16b. KIND OF BUSINESS/INDUSTRY: Newark Fire Department	
17. FATHER'S NAME (First, Middle, Last): Jacob Abrahms		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Rosen	
19a. INFORMANT'S NAME (Type/Print): Norma A. Kass (Daughter)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10500 Rockville Pike, #1601; Rockville, Md. 20852	
20a. METHOD OF DISPOSITION: XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Lebanon Cemetery	20c. LOCATION — City or Town, State: Iselin, New Jersey	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frank A. Stone		22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike; Rockville, Md. 20852	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ACUTE RENAL FAILURE	1 WEEK
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. UNKNOWN CAUSE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF): —	
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 X Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A.D. Patel Attending Physician	29c. LICENSE NUMBER: D 18084	29d. DATE SIGNED (Month, Day, Year): ▶ 8/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D.D. PATEL, M.D. 6121 MONTROSE RD ROCKVILLE, MD 20852

31. DATE FILED (Month, Day, Year): AUG 24 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

10+1

DHMH-18 Rev 1/89

Items:23,27 per ME G-657
11-17-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24975
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
Willie	Clarence	Barnes	8 / 12 / 89	8:02 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	6. BIRTHPLACE (State or Foreign Country)
417-72-3581	1 [X] M 2 [ ] F	36 YRS.			Dec 2 1952	Troy Alabama

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Washington Adventist Hospital	Takoma Park	Montgomery

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Montgomery	Takoma Park	1 [X] YES 2 [ ] ND

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
7719 Eastern Ave,	20912	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [X] YES 2 [ ] NO 5-12-72TO 5-11-73	1 [ ] YES 2 [X] NO Specify:	Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
9th		SUPREVISOR	G.W.U.HOSPITAL

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
EARLIE BARNES	Lillie Bell Williams

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Earlie Barnes(father)	7719 Eastern Ave.Takoma Park MD. 20912

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Congressional Cemetery	1801 E ST.S.E.WASH.D.C.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ James E Dillenn 799	MODERN FUNERAL HOME 3821 14th ST.N.W D.C.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac arrhythmia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	OCME	▶ 8/13/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles P. Kokes, M.D. - Deputy Chief 111 Penn St. Balto.MD.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 18 89	Trina Davidson-Randall

(3)

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24976

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSHUA BERNARD BROOMFIELD			2. DATE OF DEATH (Month, Day, Year): AUGUST 25 1989	3. TIME OF DEATH: 12:19 AM
4. SOCIAL SECURITY NUMBER: N/A	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS: 1 / MIN.	7. DATE OF BIRTH (Month, Day, Year): AUG 24 1989	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: PRINCE GEORGE'S	10c. CITY, TOWN OR LOCATION: CAMP SPRINGS	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 4180 SUITLAND ROAD, APT 202		10f. ZIP CODE: 20746	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A	16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): HENRY BERNARD BROOMFIELD	18. MOTHER'S NAME (First, Middle, Maiden Surname): PAMELA DENISE ADAMS	
19a. INFORMANT'S NAME (Type/Print): HENRY B. BROOMFIELD	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4180 SUITLAND ROAD, APT 202, CAMP SPRINGS, MD 20746	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NATIONAL NAVAL MEDICAL CENTER, BETHESDA MD	20c. LOCATION — City or Town, State:
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶	22. NAME AND ADDRESS OF FACILITY	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. EXTREME PREMATURITY (21 WEEKS, 411 GRAMS)	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 9/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DANIEL E. BRIER, LT, MC, USN	NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD 20814-5011	
31. DATE FILED (Month, Day, Year): SEP 12 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 24977

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE R. BATESON
2. DATE OF DEATH (Month, Day, Year): 8 - 17 - 1989
3. TIME OF DEATH: 9:45 A M
4. SOCIAL SECURITY NUMBER: 220-54-6952
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 91 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1-21-1898
8. BIRTHPLACE (State or Foreign Country): MICH.

9a. FACILITY NAME (If not institution, give street and number): MEDIANTIC MANOR AT LAYHILL
9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING, MD
9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: MONTGOMERY
10c. CITY, TOWN OR LOCATION: SILVER SPRING.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2601 BEL PRE RD.
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY? U.S.A

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 5
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NEVER EMPLOYED
16b. KIND OF BUSINESS/INDUSTRY: NONE

17. FATHER'S NAME (First, Middle, Last): RICHARD BATESON
18. MOTHER'S NAME (First, Middle, Maiden Surname): CATHERINE E. ROONEY

19a. INFORMANT'S NAME (Type/Print): Sr. JOHN GABRIEL
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9400 NEW HARMONY RD., EVANSVILLE, IND 47712

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEM.
20c. LOCATION — City or Town, State: SILVER SPRING, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James E. Devol
22. NAME AND ADDRESS OF FACILITY: DEVOL FUNERAL HOME, 2222 Wisc. Ave., N.W., Wash. D.C.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure	1 day
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Arteriosclerotic Heart Disease	4 years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: H.T. Benack MD
29c. LICENSE NUMBER: D 552
29d. DATE SIGNED (Month, Day, Year): 8/17/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R.T. BENACK MD 4115 Colie DR., Wheaton, Md 20906
31. DATE FILED (Month, Day, Year): AUG 25 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24978

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Annette M. Boesel				2. DATE OF DEATH (Month, Day, Year): 8-15-89	3. TIME OF DEATH: 6A M
4. SOCIAL SECURITY NUMBER: 083-14-3340	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 95 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb. 10, 1894	8. BIRTHPLACE (State or Foreign Country): Canton, Ohio
9a. FACILITY NAME (If not institution, give street and number): Fernwood House		9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda		9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Bethesda	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6530 Democracy Blvd.		10f. ZIP CODE: 20817	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: American

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home maker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Emil Chmelitzki		18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Laher	
19a. INFORMANT'S NAME (Type/Print): Barbara Ann Colby		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1200 No. Nash Street Arlington, Virginia 22209	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery	20c. LOCATION — City or Town, State: Silver Spring, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F. DeVal		22. NAME AND ADDRESS OF FACILITY: DeVol Funeral Home 2222 Wisc. Ave., NW Washington, D.C. 20007	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hypertensive Cardio Vascular Disease with Left Bundle Branch Block	15+ years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. and Chronic Organic Brain Syndrome	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURRED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michel M Healy MD	29c. LICENSE NUMBER: D05000	29d. DATE SIGNED (Month, Day, Year) ▶ 8/15/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michel M HEALY MD 5652 Fields Dr Bethesda MD 20817

31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 24979

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Kathryn Blair		2. DATE OF DEATH (Month, Day, Year): August 20, 1989	3. TIME OF DEATH: 7:00 PM M
4. SOCIAL SECURITY NUMBER: 235-18-8464	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 27, 1913 — 8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring	9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8002 Eastern Drive		10f. ZIP CODE: 20910	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Administrative Assistant	16b. KIND OF BUSINESS/INDUSTRY: U.S. Department of State
17. FATHER'S NAME (First, Middle, Last): James H. Riddle		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nell Cox	
19a. INFORMANT'S NAME (Type/Print): H. Laban White, Esq.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Lowndes Square, Suite 316, Clarksburg, WV 26302	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.	20c. LOCATION — City or Town, State: Bethesda, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Douglas C. Small M00522		22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIO RESPIRATORY ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. SEPSIS

DUE TO (OR AS A CONSEQUENCE OF):
c. ISCHEMIC COLITIS

DUE TO (OR AS A CONSEQUENCE OF):
d. PNEUMONIA

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
GASTROINTESTINAL BLEEDING - CONGESTIVE HEART FAILURE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) — 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: 23317
29d. DATE SIGNED (Month, Day, Year): ▶ 8/20/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARIO O. BELLEDONNE 14816 PHYSICIANS CN 251 ROCK.

31. DATE FILED (Month, Day, Year): AUG 24 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

6+1

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24980

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Roger Franklin Burdette
2. DATE OF DEATH: MONTH 8 DAY 17 YEAR 1989
3. TIME OF DEATH: 630 PM
4. SOCIAL SECURITY NUMBER: 216-40-5520
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 20, 1909
8. BIRTHPLACE (State or Foreign Country): Brownsville, Md.
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: College Park
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4802 Guilford Road
10f. ZIP CODE: 20740
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): 6 Years
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Agriculture Economist
16b. KIND OF BUSINESS/INDUSTRY: United Nations World Bank
17. FATHER'S NAME (First, Middle, Last): Emory W. Burdette
18. MOTHER'S NAME (First, Middle, Maiden Surname): Susie Layton
19a. INFORMANT'S NAME (Type/Print): Loraine B. Burdette (Wife)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4802 Guilford Road College Park, Maryland 20740
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory
20c. LOCATION — City or Town, State: Alexandria, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randy Brohaun
22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. respiratory arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. [illegible]

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D01499
29d. DATE SIGNED (Month, Day, Year): ▶ 8/17/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): AUG 25 89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

(10) (IVA)

DHMH-16 Rev 1/89

89 24981

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): AGNES BAKER			2. DATE OF DEATH (Month, Day, Year): August 21, 1989	3. TIME OF DEATH: 12:35 pM
4. SOCIAL SECURITY NUMBER: 577-22-8092 A	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Oct 24, 1900	8. BIRTHPLACE (State or Foreign Country): Armenia
9a. FACILITY NAME (If not institution, give street and number): Collingswood Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Washington, DC		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMSER: 4727 48th St. NW		10f. ZIP CODE: 20016		10g. CITIZEN OF WHAT COUNTRY?: U. S. A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 8+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress		16b. KIND OF BUSINESS/INDUSTRY: Department Store
17. FATHER'S NAME (First, Middle, Last): Not Available		18. MOTHER'S NAME (First, Middle, Maiden Surname): Not Available		
19a. INFORMANT'S NAME (Type/Print): Harry A. Baker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9021 Willow Valley Dr., Potomac, MD 20854		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Comfort Crematory		20c. LOCATION — City or Town, State: Alexandria, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sosn 5130 Wisconsin Av., Washington, DC 20016		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary arrest DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. arteriosclerosis, angina DUE TO (OR AS A CONSEQUENCE OF):	
	c. old age DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	25. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Frauke Westphal MD	D19785	▶ 8/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frauke Westphal, M.D. 809 Viers Mill Rd. Rockville, MD 20851

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24982
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HOWARD CORNELL BUGBEE

2. DATE OF DEATH (Month, Day, Year): 8-28-89

3. TIME OF DEATH: 12 15 A M

4. SOCIAL SECURITY NUMBER: 279-14-6802

5. SEX: 1 ☒ M 2 ☐ F

6. AGE (In yrs. last birthday): 85 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): April 1, 1904

8. BIRTHPLACE (State or Foreign Country): Nebraska

9a. FACILITY NAME (If not institution, give street and number): Sharon Nursing Home

9b. CITY, TOWN OR LOCATION OF DEATH: Olney, MD

9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD.

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Derwood

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 7320 Blanchard Dr.

10f. ZIP CODE: 20855

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): President-Executive

16b. KIND OF BUSINESS/INDUSTRY: Natural Rubber Bureau

17. FATHER'S NAME (First, Middle, Last): Fred Bugbee

18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Cornell

19a. INFORMANT'S NAME (Type/Print): Robert S. Yount

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7320 Blanchard Dr. Derwood, MD. 20855

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Chambers Crematory

20c. LOCATION — City or Town, State: Riverdale, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas S. Chambers #670

22. NAME AND ADDRESS OF FACILITY: W.W. Chambers Co. Inc. 9241 Columbia Blvd. Silver Spring, MD. 20910

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ATHEROSCLEROTIC CORONARY DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SENILE DEMENTIA
INTRA CEREBRAL HEMORRHAGE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ted E. Howe MD

29c. LICENSE NUMBER: D33700

29d. DATE SIGNED (Month, Day, Year): 8-28-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TED E. HOWE. MD OLNEY MD 20832

31. DATE FILED (Month, Day, Year): AUG 29 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

4 2

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24983
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BESSIE S. CAMDEN

2. DATE OF DEATH (Month, Day, Year): AUG 19, 1989

3. TIME OF DEATH: 0632 M

4. SOCIAL SECURITY NUMBER: 579-28-6817

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 85 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): FEB 24, 1904

8. BIRTHPLACE (State or Foreign Country): LYNCHBURG, VA

9a. FACILITY NAME (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER

9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA, MD

9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: HOWARD

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 6620 Washington Blvdlot F-1

10f. ZIP CODE: 21227

10g. CITIZEN OF WHAT COUNTRY?: U.S.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER

16b. KIND OF BUSINESS/INDUSTRY: NONE

17. FATHER'S NAME (First, Middle, Last): CHARLES STAUFFER

18. MOTHER'S NAME (First, Middle, Maiden Surname): HORTENCE BLANKS

19a. INFORMANT'S NAME (Type/Print): ANN CAMDEN CAMPBELL

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3358 CRUMPTON SOUTH, LAUREL, MD 20707

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON NATIONAL CEMETARY

20c. LOCATION — City or Town, State: ARLINGTON, VA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ [signature]

22. NAME AND ADDRESS OF FACILITY
Gary L. Kaufman Funeral Homes
5695 Main Street, Elkridge, Md. 21227

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PULMONARY EMBOLISM
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: 218-78-6123

29d. DATE SIGNED (Month, Day, Year) ▶ Aug 19 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
W. L. DAhut, NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD

31. DATE FILED (Month, Day, Year): AUG 23 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

8

Items:18,19a,19b per FH G-656
10-30-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24984

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROSIE CHACONAS			2. DATE OF DEATH (Month, Day, Year): 8 19 89	3. TIME OF DEATH: 2130 M
4. SOCIAL SECURITY NUMBER: 214-58-3655	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JULY 10, 1908	8. BIRTHPLACE (State or Foreign Country): SPARTA, GREECE
9a. FACILITY NAME (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: TAKOMA PARK		9c. COUNTY OF DEATH: MONTGOMERY
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 305 LANARK WAY		10f. ZIP CODE: 20901		10g. CITIZEN OF WHAT COUNTRY?: GREECE
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): GEORGE LIAPERDOS		18. MOTHER'S NAME (First, Middle, Maiden Surname): ~~MARY KALAURITE~~ Mary Kalauritenou		
19a. ~~GEORGE TSAKONAS~~ Anthanasios Chaconas		19b. MAILING ADDRESS: ~~11608 GEORGIA AVENUE, WHEATON, MARYLAND 20902~~ 305 Lanark Way Silver Spring, Md. 20901		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN		20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Andrea D. Cole		22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute ~~Anno~~ Myelo-monocytic leukemia	3 mos
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. & intracerebral Bleeding	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Severe congestive heart failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D14404	29d. DATE SIGNED (Month, Day, Year): 8/20/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles L Franklin 11120 New Hampshire Ave Silver Spring Md 20904		
31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24985

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Wellington N. Crutchfield			2. DATE OF DEATH (Month, Day, Year): Aug 24, 1989	3. TIME OF DEATH: 8:37 Pm M
4. SOCIAL SECURITY NUMBER: 578-42-0254	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Mar 16, 1934	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 16 Martin's Lane		9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 16 Martin's Lane		10f. ZIP CODE: 20850	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES: Korean War	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specity Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] ND Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver	16b. KIND OF BUSINESS/INDUSTRY: None	
17. FATHER'S NAME (First, Middle, Last): Henry Crutchfield		18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Prather	
19a. INFORMANT'S NAME (Type/Print): Mrs Joanne L. Crutchfield		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16 Martin's Lane, Rockville, Md #20850	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George R. Snowden		22. NAME AND ADDRESS OF FACILITY: Snowden Funeral Home #20850, 246 N. Washington St, Rockville, Md	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PANCREATIC CARCINOMA	3 Mo's
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: NONE

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] ND	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] ND	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Daniel Rosenthal	29c. LICENSE NUMBER: D04766	29d. DATE SIGNED (Month, Day, Year): ▶ 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 10400 CONNECTICUT AVE STE 606 KENSINGTON, MD 20895

31. DATE FILED (Month, Day, Year): AUG 29'89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

12

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24986 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gabriela Canales Canales
2. DATE OF DEATH: MONTH 8 DAY 14 YEAR 89
3. TIME OF DEATH: 3:50 M
4. SOCIAL SECURITY NUMBER: None
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS 2 / MIN. 30
7. DATE OF BIRTH (Month, Day, Year): 8/14/89
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): HOLY CROSS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING
9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: MONTGOMERY
10c. CITY, TOWN OR LOCATION: Silver Spring
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2420 Ross Rd #101
10f. ZIP CODE: 20910
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☒ YES 2 ☐ NO Specify: El Salvador
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 0 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None
16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): Edward Huanucho
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa Canales
19a. INFORMANT'S NAME (Type/Print): Rosa Canales
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as item # 10
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cem.
20c. LOCATION — City or Town, State: Silver Spring, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael C. Nelson
22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, DC 20016

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CARDIORESPIRATORY FAILURE	2½ hr
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	MULTIPLE CONGENITAL ANOMALIES	2½ Hr
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ECTOPIA CORDIS, OMPHALOCELE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER: AW6927389
29d. DATE SIGNED (Month, Day, Year): ▶ 8/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S. WYNER MD HOLY CROSS HOSPITAL, SILVER SPRING MD 20901
31. DATE FILED (Month, Day, Year): AUG 30 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 24987

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
ARTHUR	I.	COLBERT	August 29, 1989	5:30 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
076-10-9171	1 [X] M 2 [ ] F	86 YRS.			May 7, 1903	New York

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
11550 Stewart Lane, #210	Silver Spring	Montgomery

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Montgomery	Silver Spring	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
11550 Stewart Lane, #210	20904	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Fuel Specialist	U.S. Government

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Henry Colbert	Unknown

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edmund Colbert (Son)	12411 Sexton Lane; Bowie, Maryland 20715

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	King David Memorial Garden	Falls Church, Va.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Gary M. Lee	DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike; Rockville, Md. 20852

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARCINOMA OF LUNG	4 MONTHS.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined			1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Norman K Bowen	D00574	▶ Aug 29, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
NORMAN K BOWEN MD 323 SUPERIOR LANE BOWIE, MD 20715

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 '89	Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24988

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jack Coune
2. DATE OF DEATH (Month, Day, Year): 8 25 1989
3. TIME OF DEATH: 9:20 AM
4. SOCIAL SECURITY NUMBER: 213-05-8556
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): April 7,1904
8. BIRTHPLACE (State or Foreign Country): Greece
9a. FACILITY NAME (If not institution, give street and number): Hebrew Home of Greater Washington
9b. CITY, TOWN OR LOCATION OF DEATH: Rockville
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Silver Spring
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1713 Mayhew Drive
10f. ZIP CODE: 20902
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [✓] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES [XX] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES [XX] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Business Owner(Retired)
16b. KIND OF BUSINESS/INDUSTRY: Restaurateur
17. FATHER'S NAME (First, Middle, Last): Jacob Coune
18. MOTHER'S NAME (First, Middle, Maiden Surname): Matilda Naar
19a. INFORMANT'S NAME (Type/Print): Irving Boker (Son-in-Law)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1713 Mayhew Drive; Silver Spring, Md. 20902
20a. METHOD OF DISPOSITION: 1 [XX] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Lebanon Cemetery
20c. LOCATION — City or Town, State: Adelphi,Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gary M. Gue
22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike; Rockville, Md. 20852

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. LEFT LUNG ABSCESS	5months
DUE TO (OR AS A CONSEQUENCE OF):	b. BRONCHIECTASIS	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c.	
DUE TO (OR AS A CONSEQUENCE OF):	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO N/A
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Barbara Carroll, MD staff physician
29c. LICENSE NUMBER: D38392
29d. DATE SIGNED (Month, Day, Year): 8/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BARBARA CARROLL, M.D. HEBREW HOME, 6105 MONTROSE RD, ROCKVILLE MD 20852
31. DATE FILED (Month, Day, Year): AUG 28 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randell

DHMH-16 Rev 1/89

5

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24989 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Curtis G. Dunn		2. DATE OF DEATH (Month, Day, Year): 8 18 89	3. TIME OF DEATH: 1331 M
4. SOCIAL SECURITY NUMBER: 577-46-0841	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 54 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 8-9-35
8. BIRTHPLACE (State or Foreign Country): Washington, DC			
9a. FACILITY NAME (If not institution, give street and number): WASHINGTON ADVENTIST HOSP	9b. CITY, TOWN OR LOCATION OF DEATH: TAKOMA PARK	9c. COUNTY OF DEATH: MONTGOMERY	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Berwyn Heights	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5614 Berwyn Road	10f. ZIP CODE: 20740	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): None	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter	16b. KIND OF BUSINESS/INDUSTRY: Construction	
17. FATHER'S NAME (First, Middle, Last): Bertram E. Dunn	18. MOTHER'S NAME (First, Middle, Maiden Surname): Lena Spencer		
19a. INFORMANT'S NAME (Type/Print): Constance A. Dunn (Wife)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5614 Berwyn Road Berwyn Heights, Md. 20740		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery	20c. LOCATION — City or Town, State: Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randy Brohawn	22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SHOCK	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. UROSEPSIS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. MALLIGNANT MESOTHELIOMA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
A Qadri	D 22910	▶ 8.18.1989.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ASIF S. QADRI, 4700 BERWYN HOUSE RD, COLLEGE PK MD 20740

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 '89	Julia Davidson-Randall AUG 25 '89

16 IVA

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24990

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN W. DUNN				2. DATE OF DEATH (Month, Day, Year): Aug. 21 1989	3. TIME OF DEATH: 6:40 PM M
4. SOCIAL SECURITY NUMBER: 278-22-3061	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 13, 1925	8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): 14405 Ansted Drive			9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 14405 Ansted Drive		10f. ZIP CODE: 20904	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1-12; College (1-4 or 5+): ——	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Asst. Manager	16b. KIND OF BUSINESS/INDUSTRY: Perry Lumber Co.	
17. FATHER'S NAME (First, Middle, Last): Charles Dunn		18. MOTHER'S NAME (First, Middle, Maiden Surname): Flora E. Davis	
19a. INFORMANT'S NAME (Type/Print): June Dunn		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14405 Ansted Drive, Silver Spring, Md. 20904	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery	20c. LOCATION — City or Town, State: Brentwood, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. 20904	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Colon Cancer	2 years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Bruce A. Silver, MD	29c. LICENSE NUMBER: D21463	29d. DATE SIGNED (Month, Day, Year): ▶ Aug. 21, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bruce A. Silver, MD 106 Irving Street, NW Washington, DC 20010		
31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMN-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12

89 24991

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LEOPOLD (N.M.I.) DIAMOND			2. DATE OF DEATH (Month, Day, Year): Aug. 28 1989	3. TIME OF DEATH: 8:30 a.m
4. SOCIAL SECURITY NUMBER: 084 20 4498	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Dec 17 1908	8. BIRTHPLACE (State or Foreign Country): Yugoslavia
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 708 Hermleigh Road		10f. ZIP CODE: 20902		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): Yes	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Medical Doctor		16b. KIND OF BUSINESS/INDUSTRY: Medicine
17. FATHER'S NAME (First, Middle, Last): Maurycy Diamant		18. MOTHER'S NAME (First, Middle, Maiden Surname): Laura Blaric		
19a. INFORMANT'S NAME (Type/Print): John M. Diamond		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 310 King George Rd. Greenville, N.C. 27858		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore/Washington Crematory		20c. LOCATION — City or Town, State: Laurel, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William F. Conrad		22. NAME AND ADDRESS OF FACILITY: TAKOMA FUNERAL HOME, INC. 254 Carroll St. N. W. WashingtonDC		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma of Pancreas	1 Week
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: D0D0J9

29d. DATE SIGNED (Month, Day, Year): ▶ 29 Aug 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael Leibowitz, MD 1112 N. Howard St, Rockville, MD 20904

31. DATE FILED (Month, Day, Year): AUG 29 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24992
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Henrietta F. Elliott			2. DATE OF DEATH: MONTH 8 DAY 26 YEAR 89	3. TIME OF DEATH: 9:09 PM
4. SOCIAL SECURITY NUMBER: 472-32-7060	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5/5/97	8. BIRTHPLACE (State or Foreign Country): Wisconsin
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Rockville	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Minnesota	10b. COUNTY: Olmsted	10c. CITY, TOWN OR LOCATION: Rochester	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1004 West Center Street		10f. ZIP CODE: 55902	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary	16b. KIND OF BUSINESS/INDUSTRY: Bank	
17. FATHER'S NAME (First, Middle, Last): Louis Fischer		18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise Gstalder	
19a. INFORMANT'S NAME (Type/Print): Kendra Biddick		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22817 Clarkbrooke Dr., Clarksburg, MD 20871	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore-Washington Crematory	20c. LOCATION — City or Town, State: Laurel, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home Inc. 7601 Sandy Spring Road, Laurel, MD 20707	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Pneumonia — 4 hr

DUE TO (OR AS A CONSEQUENCE OF):
b. Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. Renal Failure

DUE TO (OR AS A CONSEQUENCE OF):
d. Chronic Obstructive Pulmonary Disease

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: 32610	29d. DATE SIGNED (Month, Day, Year): ▶ 8-27-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas J. McNamara 19642 Club House Rd, Gaithersburg MD		
31. DATE FILED (Month, Day, Year): AUG 30 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24993

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): KRISTIANA ELIZABETH FUQUA
2. DATE OF DEATH (Month, Day, Year): 08 26 89
3. TIME OF DEATH: 8:45 A M
4. SOCIAL SECURITY NUMBER: 305-04-6282
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 1 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 01 07 88
8. BIRTHPLACE (State or Foreign Country): GERMANY
9a. FACILITY NAME (If not institution, give street and number): NAVAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA
9c. COUNTY OF DEATH: MONTGOMERY COUNTY

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: PRINCE GEORGES
10c. CITY, TOWN OR LOCATION: TEMPLE HILLS
10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2106 REDWOOD TERRACE
10f. ZIP CODE: 20748
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None
16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): KENNETH ROBERT FUQUA , II
18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH RUTH CHESELDINE
19a. INFORMANT'S NAME (Type/Print): KENNETH ROBERT FUQUA,II
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2106 REDWOOD TERRACE,TEMPLE HILLS,MD 20748
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Grandview Memorial Gardens
20c. LOCATION — City or Town, State: Madison, Indiana
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellen H. Rapp
22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PROGRESSIVE DEGENERATIVE NEUROLOGIC DISORDER
DUE TO (OR AS A CONSEQUENCE OF): OF UNKNOWN ETIOLOGY
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. COMPLICATED BY RESPIRATORY FAILURE.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Robert J. Ferrall Ferrall
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 08/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R. FERRALL, LT, MC, USNR — NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD 20814-5011
31. DATE FILED (Month, Day, Year): AUG 28 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 24994

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Leon Webber Fuller			2. DATE OF DEATH (Month, Day, Year): August 22, 1989	3. TIME OF DEATH: 4:10 a M
4. SOCIAL SECURITY NUMBER: 557-60-7333	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 94 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 17,1895	8. BIRTHPLACE (State or Foreign Country): Illinois
9a. FACILITY NAME (If not institution, give street and number): 4701 Willard Avenue #1221		9b. CITY, TOWN OR LOCATION OF DEATH: Chevy Chase		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Chevy Chase	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4701 Willard Avenue #1221		10f. ZIP CODE: 20815	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW 1	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Officer	16b. KIND OF BUSINESS/INDUSTRY: State Department
17. FATHER'S NAME (First, Middle, Last): Albert Fuller		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Webber	
19a. INFORMANT'S NAME (Type/Print): Margaret P. Fuller		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4701 Willard Avenue #1221 Chevy Chase, Maryland 20815	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Montgomery Crematorium Inc.	20c. LOCATION — City or Town, State: Bethesda, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George T. Kephart M00335		22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Intercerebral Hemorrhage	13 Days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Epidural Hematoma

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James H. Brodsky	29c. LICENSE NUMBER: D-20297	29d. DATE SIGNED (Month, Day, Year): August 22, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James H. Brodsky M.D. 4701 Willard Avenue #224 Chevy Chase, Maryland 20815

31. DATE FILED (Month, Day, Year): AUG 24 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

10

Items:23,27 per ME G-658
12-12-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 24995

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John W. George			2. DATE OF DEATH (Month, Day, Year): 8-19-89	3. TIME OF DEATH: 5:50PM M
4. SOCIAL SECURITY NUMBER: 235-02-8163	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 27 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-25-1961	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): 10921 Inwood Street	9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring	9c. COUNTY OF DEATH: Montgomery County		

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: 10921 Inwood St. Silver Spring	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 10921 Inwood St.	10f. ZIP CODE:	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12	College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disabled	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Delbert George		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bonnie Kesner	
19a. INFORMANT'S NAME (Type/Print): Delbert George	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R.F.D. 3 Purgitsville W. Va.		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Old Pine Cemet	20c. LOCATION — City or Town, State: Purgitsville W. Va.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas J. Fletcher	22. NAME AND ADDRESS OF FACILITY: Thomas J. Fletcher & Son Westminster		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral Palsy — DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. — DUE TO (OR AS A CONSEQUENCE OF):

c. — DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home [X] Residence 8 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 8-20-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan, M.D.	111 Penn Street, Baltimore, MD 21201	vc
31. DATE FILED (Month, Day, Year): AUG 22 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 24996

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert Charles Gooch			2. DATE OF DEATH (Month, Day, Year): August 23, 1989	3. TIME OF DEATH: 10:37 pm M
4. SOCIAL SECURITY NUMBER: 220-44-1386	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov 28, 1898	8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Chevy Chase	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4807 DeRussey Parkway		10f. ZIP CODE: 20815	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Director of Administration	16b. KIND OF BUSINESS/INDUSTRY: Library of Congress	
17. FATHER'S NAME (First, Middle, Last): Charles Gooch		18. MOTHER'S NAME (First, Middle, Maiden Surname): Flora Humphreys	
19a. INFORMANT'S NAME (Type/Print): Elizabeth French Gooch		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4807 DeRussey Pkwy., Chevy Chase, MD 20815	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery	20c. LOCATION — City or Town, State: Suitland, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Henry D. Ford		22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons, 5130 Wisconsin Av., Washington, DC 20016	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIAC INSUFFICIENCY	2 wks
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ARTERIOSCLEROTIC HEART DISEASE	10 yrs
DUE TO (OR AS A CONSEQUENCE OF): AND		
	c. CARDIOMYOPATHY	12 months
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC LYMPHOCYTIC LEUKEMIA

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Eugene P. Libre' M.D.	29c. LICENSE NUMBER: D09740	29d. DATE SIGNED (Month, Day, Year) ▶ 24 Aug 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Eugene P. Libre M.D.	10400 Connecticut Avenue, Kensington, Md. 20895	
31. DATE FILED (Month, Day, Year): AUG 25'89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24997
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Pearl	M.	Griesemer	August 24, 1989	10:55 AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
579-32-0551	1 ☐ M 2 ☒ F	84 YRS.			May 28, 1905	New York

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Kensington Gardens Nursing Home	Kensington	Montgomery

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Montgomery	Potomac	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
12121 Gatewater Drive	20854	United States

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Procurement Officer	U.S. Government

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Orlando K. Monroe	Eleanor Monroe

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
H. Lois Hessler	12121 Gatewater Drive Potomac, Maryland 20854

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Maryland Veterans Cemetery	Cheltenham, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY
▶ [signature]	M00689	Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Aspiration Pneumonia	2 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Aspiration due to severe Alzheimer's disease & interruption of Swallowing Mechanism

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature], M.D.	D09834	▶ August 24, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Barry N. Rosenbaum, M.D. 3720 Farragut Avenue, Kensington, Maryland 20895

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 '89	Julia Davidson-Randell

DHMH-16 Rev 1/89

89 24998

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Chelsea Catlin Graybill GRAYBILL		2. DATE OF DEATH (Month, Day, Year): 08 24 89	3. TIME OF DEATH: 7:13 PM
4. SOCIAL SECURITY NUMBER: none	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 0 YRS. IF UNDER 1 YEAR: MONTHS 0 DAYS 0 IF UNDER 24 HRS.: HOURS 3 MIN. 3	7. DATE OF BIRTH (Month, Day, Year): 08,24,89
8. BIRTHPLACE (State or Foreign Country): MARYLAND			
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring	9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT			
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: TAKOMA PARK	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 411 BOSTON AVE	10f. ZIP CODE: 20912	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): --- College (1-4 or 5+): ----	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ----	16b. KIND OF BUSINESS/INDUSTRY: -----	
17. FATHER'S NAME (First, Middle, Last): DAVID R. GRAYBILL	18. MOTHER'S NAME (First, Middle, Maiden Surname): BETH L CULLISON		
19a. INFORMANT'S NAME (Type/Print): David R. Graybill	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 411 Boston Ave, Takoma Park, MD., 20912		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore/Washington Crematory	20c. LOCATION — City or Town, State: Laurel, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William S. Clark	22. NAME AND ADDRESS OF FACILITY: TAKOMA FUNERAL HOME, INC. 254 Carroll Street, N. W. Wash. D.C.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Extreme Prematurity	3 hrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
	M	1 ☐ YES 2 ☐ NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Leonard E. Weisman MD	D27965	▶ 08,24,89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Leonard E. Weisman MD, 11909 Old Gate Place, Rockville, M.D. 20852

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 24999 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen Goldberg
2. DATE OF DEATH (Month, Day, Year): 8 26 89
3. TIME OF DEATH: 855 PM
4. SOCIAL SECURITY NUMBER: 084-18-9386
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 2-26-23
8. BIRTHPLACE (State or Foreign Country): NJ
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Silver Spring
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 8484 16th Street # 500
10f. ZIP CODE: 20910
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Receptionist
16b. KIND OF BUSINESS/INDUSTRY: Computer Firm
17. FATHER'S NAME (First, Middle, Last): Joseph Gunty
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Kuller
19a. INFORMANT'S NAME (Type/Print): David L. Goldberg (Husband)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8484 16th Street, #500; Silver Spring, Md. 20910
20a. METHOD OF DISPOSITION: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Judean Memorial Gardens
20c. LOCATION — City or Town, State: Olney, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frank A. Stone
22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 Rockville Pike; Rockville, Md. 20852

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Chronic obstructive lung disease.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Carroll V. Mahner M.D.
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): 8-27-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): AUG 28 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

15

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-25000

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be detached by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Paul Heyse			2. DATE OF DEATH (Month, Day, Year): Aug. 2, 89	3. TIME OF DEATH: 6 52 M
4. SOCIAL SECURITY NUMBER: 062-03-6957	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): MAY 9, 1909	8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hosp.		9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: N.Y.	10b. COUNTY: NASSAU	10c. CITY, TOWN OR LOCATION: VALLEY STREAM	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 180 ELM ST.		10f. ZIP CODE: 11580	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ELECTRICAL ENGINEER	16b. KIND OF BUSINESS/INDUSTRY: OIL CO.
17. FATHER'S NAME (First, Middle, Last): WILLIAM A. HEYSE		18. MOTHER'S NAME (First, Middle, Maiden Surname): EMMA LOHR	
19a. INFORMANT'S NAME (Type/Print): RUTH HEYSE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WOODLAWN CEMETERY	20c. LOCATION — City or Town, State: BRONX, N.Y.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. W. Chambers M00091		22. NAME AND ADDRESS OF FACILITY: W. W. CHAMBERS CO., RIVERDALE, MD.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Dis'	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John S. Rogers M.D.	29c. LICENSE NUMBER: D08975	29d. DATE SIGNED (Month, Day, Year): Aug. 2 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN S. ROGERS M.D. 1919 SEMINARY RD., SILVER SPRING, MD. 20910

31. DATE FILED (Month, Day, Year): AUG 04 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25001

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Francis J. Haas					2. DATE OF DEATH (Month, Day, Year): August 22, 1989	3. TIME OF DEATH: 12:01 A M	
4. SOCIAL SECURITY NUMBER: 102-20-9808	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 61 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 23, 1927	8. BIRTHPLACE (State or Foreign Country): New York	
9a. FACILITY NAME (If not institution, give street and number): 3844 Gateway Terrace			9b. CITY, TOWN OR LOCATION OF DEATH: Burtonsville		9c. COUNTY OF DEATH: Montgomery		
RESIDENCE OF DECEDENT							
10a. STATE: New York	10b. COUNTY: Queens		10c. CITY, TOWN OR LOCATION: Glendale		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO		
10e. STREET AND NUMBER: 69-18 67th Place			10f. ZIP CODE: 11385		10g. CITIZEN OF WHAT COUNTRY? United States		
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): 2			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesman		16b. KIND OF BUSINESS/INDUSTRY: Toys		
17. FATHER'S NAME (First, Middle, Last): Aloysius Haas			18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Dannenhofer				
19a. INFORMANT'S NAME (Type/Print): Karen Haas Pfister			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3844 Gateway Terrace, Burtonsville, MD 20866				
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Calvary Cemetery		20c. LOCATION — City or Town, State: Long Island City, New York		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellen H. Rapp			22. NAME AND ADDRESS OF FACILITY: Hess-Miller Funeral Home 11379, 64-19 Metropolitan Ave., Middle Village, NY				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC Lung Cancer	3mo
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) / 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ralph V. Boccia, M.D.

29c. LICENSE NUMBER: D29615

29d. DATE SIGNED (Month, Day, Year): ▶ August 22, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ralph V. Boccia, M. D., 14808 Physicians Lane, Rockville, MD 20850

31. DATE FILED (Month, Day, Year): AUG 23 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

20

ITEM:1 per FH G-654
8-30-89 ij

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25002
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~Aquila~~ AKILAH J. Johnson			2. DATE OF DEATH (Month, Day, Year): 8-20-89	3. TIME OF DEATH: 9:08AM M
4. SOCIAL SECURITY NUMBER: N/A	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS 16 DAYS — IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): August4,1989	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park		9c. COUNTY OF DEATH: Montgomery County
RESIDENCE OF DECEDENT				
10a. STATE: Md	10b. COUNTY: Prince Georges'	10c. CITY, TOWN OR LOCATION: Hyattsville		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2109 Guilford Road #103		10f. ZIP CODE: 20783		10g. CITIZEN OF WNAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A	16b. KIND OF BUSINESS/INDUSTRY: N/A		
17. FATHER'S NAME (First, Middle, Last): Arthur Johnson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Patricia Homes		
19a. INFORMANT'S NAME (Type/Print): Patricia Homes	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2109 Guilford Road #103, Hyattsville , Md 20783			
20a. METNOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Memorial Park	20c. LOCATION — City or Town, State: Landover, Md		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J. B. [illegible] Jr.	22. NAME AND ADDRESS OF FACILITY: J. B. [illegible] Funeral Home [illegible] Rd 1494			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congenital Heart Abnormality	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
☒ YES 2 ☐ NO	☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined			1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Margarita A. Korell, MD	OCME	▶ 8-21-89

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print): Margarita A. Korell,MD 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
8 29 89	Julia Davidson-Randall

DHMH-18 Rev 1/89

Item:18 per FH G-656
10-30-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25003 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Bernyl Howard Jackson			2. DATE OF DEATH (Month, Day, Year): August 25, 1989	3. TIME OF DEATH: 8:08 A M
4. SOCIAL SECURITY NUMBER: 503-12-1050	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 5, 1923	8. BIRTHPLACE (State or Foreign Country): South Dakota
9a. FACILITY NAME (If not institution, give street and number): 11903 Smoketree Road		9b. CITY, TOWN OR LOCATION OF DEATH: Potomac		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Potomac	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11903 Smoketree Road		10f. ZIP CODE: 20854	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 3+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Marketing Representative	16b. KIND OF BUSINESS/INDUSTRY: Defense Electronics
17. FATHER'S NAME (First, Middle, Last): Bert Wilbur Jackson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Myrtle Maude McClellan ~~Myrtle Maude McClenman~~	
19a. INFORMANT'S NAME (Type/Print): Awanda M. Jackson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11903 Smoketree Road, Potomac, MD 20854	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory	20c. LOCATION — City or Town, State: Silver Spring, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellen W. Rapp		22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Colon Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kenneth Miller MD	29c. LICENSE NUMBER: D 33686	29d. DATE SIGNED (Month, Day, Year): ▶ August 25, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): Kenneth Miller, M. D., 18111 Prince Philip Drive, Olney, MD 20832

31. DATE FILED (Month, Day, Year): AUG 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

ONMH-16 Rev 1/89

15

89 25004

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(4)

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LILLIAN JOSEPHINE JULIAN			2. DATE OF DEATH (Month, Day, Year): 8 23 89	3. TIME OF DEATH: 2:15 PM
4. SOCIAL SECURITY NUMBER: 215-34-3043	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 10/14/05	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE	9c. COUNTY OF DEATH: MONTGOMERY	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Gaithersburg	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 301 Russell Avenue	10f. ZIP CODE: 20877	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): 2 Years	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Jehu Miller		18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Morgan	
19a. INFORMANT'S NAME (Type/Print): Ruth M. Earnshaw		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 506 County Park Drive, Winchester, Va. 22601	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery	20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randy R. Brohawn		22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Balto. Avenue, Hyattsville, Md. 20781	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. COLON PERFORATION	3 HOURS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC GASTROINTESTINAL BLEEDING

IRON DEFICIENCY ANEMIA

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO N/A

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Alan N. Schulman MD	29c. LICENSE NUMBER: D16824	29d. DATE SIGNED (Month, Day, Year): 8/23/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 9715 MEDICAL CENTER DRIVE - SUITE 404 - ROCKVILLE, MD. 20850		
31. DATE FILED: AUG 25 '89	32. DEPUTY REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25005
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GENEVIEVE SHIRLEY JONES		2. DATE OF DEATH (Month, Day, Year): AUGUST 28 1989	3. TIME OF DEATH: 3:58 A M
4. SOCIAL SECURITY NUMBER: 577-46-2657	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 54 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): AUG 7 1935
8. BIRTHPLACE (State or Foreign Country): DISTRICT OF COLUMBIA			
9a. FACILITY NAME (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER	9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA	9c. COUNTY OF DEATH: MONTGOMERY	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: PRINCE GEORGE'S	10c. CITY, TOWN OR LOCATION: CAMP SPRINGS	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1123 BEDFORD DRIVE	10f. ZIP CODE: 20335	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOME MAKER	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): EMERSON DELANEY DUVALL	18. MOTHER'S NAME (First, Middle, Maiden Surname): EVELYN CARLUCCI		
19a. INFORMANT'S NAME (Type/Print): CYNTHIA G. HARTMAN	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1123 BEDFORD DRIVE, AFB, MD 20335		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Huntt Crematory	20c. LOCATION — City or Town, State: Waldorf, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Huntt Funeral Home P. O. Box 156, Waldorf, Md. 20604-0156		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. SMALL CELL LUNG CARCINOMA
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: R L Morrissey M.D	29c. LICENSE NUMBER: D-34250	29d. DATE SIGNED (Month, Day, Year): ▶ 28 Aug 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R. L. MORRISSEY, LCDR, MC, USN	NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD 20814-5011	
31. DATE FILED (Month, Day, Year): AUG 29 '89	32. REGISTRAR'S SIGNATURE: Mia Davidson-Randall	

DHMH-16 Rev 1/89

89 25006

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Sarah	Evans	King	August 21, 1989	4:45 PM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
578-26-7318	1 ☐ M 2 ☒ F	94 YRS.			Jan. 7, 1895	Delaware

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Randolph Hills Nursing Home	Wheaton	Montgomery

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Montgomery	Rockville	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
7 Vashi Lane	20852	United States

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12	4	Manager	Gift Shop

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Harry L. Evans	May Lindsay

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Eileen T. King	7 Vashi Lane, Rockville, Maryland 20852

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Arlington National Cemetery	Arlington, Virginia

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
M00381 ▶ Barbara Jo McMullen Lawrence	Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Alzheimer's Dementia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D34032	▶ August 22, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Jeanne P. Asher, M.D., 3720 Farragut Avenue, Kensington, Maryland 20895

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 24 '89	Julie Davidson-Randall

6

DHMH-16 Rev 1/89

89 25007

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hildegard Kitzberg					2. DATE OF DEATH (Month, Day, Year): August 22, 1989	3. TIME OF DEATH: 8:00 A M
4. SOCIAL SECURITY NUMBER: 108-32-0722	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 2, 1904	8. BIRTHPLACE (State or Foreign Country): Estonia
9a. FACILITY NAME (If not institution, give street and number): 90 Monroe Street, #303			9b. CITY, TOWN OR LOCATION OF DEATH: Rockville			9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 90 Monroe Street, #303		10f. ZIP CODE: 20850	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bake Shop Director	16b. KIND OF BUSINESS/INDUSTRY: Cornell University	
17. FATHER'S NAME (First, Middle, Last): Johannes Amjarv		18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie (UNavailable)	
19a. INFORMANT'S NAME (Type/Print): Tiina M. Raag		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10024 Weatherwood Court, Potomac, MD 20854	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory	20c. LOCATION — City or Town, State: Silver Spring, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellen W. Rapp		22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mods of dying, such as cardiac or raspiratory srrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CARDIAC ARREST AT HOME (UNWITNESSED)	? 12 HRS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	CORONARY ARTERY DISEASE	10 YRS
DUE TO (OR AS A CONSEQUENCE OF):		
c.	HYPERTENSION	10 YRS
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Roger Stevenson MD	29c. LICENSE NUMBER: D-20535	29d. DATE SIGNED (Month, Day, Year): ▶ August 22, 1989	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Roger Stevenson, Jr., M. D., 6410 Rockledge Drive, #200, Bethesda, MD 20817			
31. DATE FILED (Month, Day, Year): AUG 23 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25008 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MILTON H. KESTEN				2. DATE OF DEATH (Month, Day, Year): Aug. 27, 1989	3. TIME OF DEATH: 3:25 A. M
4. SOCIAL SECURITY NUMBER: 111 18 3083	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan. 9, 1912	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Manor Care Wheaton Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Wheaton		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: None	10b. COUNTY: None	10c. CITY, TOWN OR LOCATION: Washington, D. C.	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3100 Connecticut Ave.N.W.Apt.325		10f. ZIP CODE: 20008	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher Physics	16b. KIND OF BUSINESS/INDUSTRY: College
17. FATHER'S NAME (First, Middle, Last): Maurice Kesten		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Cohen	
19a. INFORMANT'S NAME (Type/Print): Jane Kesten		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2022 Columbia Rd.N.W.Apt.207,Wash.,D.C.20009	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Chambers Crematory	20c. LOCATION — City or Town, State: Riverdale, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W.W.Chambers M00090		22. NAME AND ADDRESS OF FACILITY: W.W.Chambers Funeral Home, 9241 Columbia Blvd.,S.S.Md.20910	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiorespiratory arrest	Immed
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Brain tumor	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Aron Primack MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): 8/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Aron Primack, MD 106 IRVING ST, NW Washington, D.C. 20010		
31. DATE FILED (Month, Day, Year): AUG 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

7

89 25009

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Minnie Howell Laue			2. DATE OF DEATH (Month, Day, Year): August 5, 1989	3. TIME OF DEATH: 12:06 AM
4. SOCIAL SECURITY NUMBER: 284-20-9969	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): October 30, 1927	8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 201 Pewter Lane		10f. ZIP CODE: 20904	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary	16b. KIND OF BUSINESS/INDUSTRY: Church	
17. FATHER'S NAME (First, Middle, Last): Forrest Howell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elnora Glaitzer	
19a. INFORMANT'S NAME (Type/Print): Robert Marshall Laue	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as item #10		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory	20c. LOCATION — City or Town, State: Silver Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellen H. Rapp	22. NAME AND ADDRESS OF FACILITY: Rapp Funeral SErvices, P.A. 933 Gist Avenue Silver SPring, MD 20910		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. cerebral aneurysm	1 MO
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: chronic obstructive pulmonary disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Walter E. Goozh MD	29c. LICENSE NUMBER: DO 1120	29d. DATE SIGNED (Month, Day, Year): ▶ 6 Aug 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WALTER E. GOOZH MD 2309 SHOREFIELD RD WHEATON MD 20902		
31. DATE FILED (Month, Day, Year): AUG 07 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

5

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25010
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES D. LOVELESS			2. DATE OF DEATH (Month, Day, Year): AUGUST 21 1989	3. TIME OF DEATH: 2:45 P M
4. SOCIAL SECURITY NUMBER: 579-30-1228	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JUNE 21, 1928	8. BIRTHPLACE (State or Foreign Country): WASHINGTON, D.C.
9a. FACILITY NAME (If not institution, give street and number): MANOR CARE NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: WHEATON		9c. COUNTY OF DEATH: MONTGOMERY
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 60 CATOCTIN COURT		10f. ZIP CODE: 20906		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: KOREA	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ELECTRICIAN		16b. KIND OF BUSINESS/INDUSTRY: E.M.C.
17. FATHER'S NAME (First, Middle, Last): JOHN P. LOVELESS		18. MOTHER'S NAME (First, Middle, Maiden Surname): GRACE E. DEERING		
19a. INFORMANT'S NAME (Type/Print): JAMES R. LOVELESS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 60 CATOCTIN COURT, SILVER SPRING, MARYLAND 20906		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOUNT OLIVET CEMETERY		20c. LOCATION — City or Town, State: WASHINGTON, D.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cancer of Pancreas metastatic to Liver	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b.	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Oliver J Lawless MD	29c. LICENSE NUMBER: D25410	29d. DATE SIGNED (Month, Day, Year): 8/21/89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): OLIVER J. LAWLESS 3701 ROSSMOOR BLVD., SILVER SPRING, MARYLAND 20906		
31. DATE FILED (Month, Day, Year): AUG 25'89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

20+1

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25011
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MORRIS SAMUEL MERSKY					2. DATE OF DEATH (Month, Day, Year): AUGUST 25 1989	3. TIME OF DEATH: 7:20P M
4. SOCIAL SECURITY NUMBER: 178-05-8084	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Dec. 13,1908	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: OLNEY		9c. COUNTY OF DEATH: MONTG	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 15100 Interlachen Drive,#701		10f. ZIP CODE: 20906	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager Pharmacist/Real Estate	16b. KIND OF BUSINESS/INDUSTRY: Thrift Drugs
17. FATHER'S NAME (First, Middle, Last): Joseph Mersky		18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Rosoff	
19a. INFORMANT'S NAME (Type/Print): Iris Mersky (Daughter)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14001 N. Commons Way; Potomac, Md. 20854	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Judean Memorial Gardens	20c. LOCATION — City or Town, State: Olney, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frank A Stone		22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike; Rockville, Md. 20852	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive Heart Failure — long

DUE TO (OR AS A CONSEQUENCE OF):
b. Atherosclerotic Heart Disease

DUE TO (OR AS A CONSEQUENCE OF):
c. Diabetes Mellitus

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 6 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature], M.D.	29c. LICENSE NUMBER: D18612	29d. DATE SIGNED (Month, Day, Year): ▶ 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. ROTSZTAIN, M.D. 3701 Rossmoor Blvd. S. Spring Md 20906

31. DATE FILED (Month, Day, Year): AUG 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

12+1

89 25012

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): RAMON E. MARTINEZ				2. DATE OF DEATH (MONTN DAY YEAR): AUG. 25, 1989	3. TIME OF DEATH: 12:05 A M
4. SOCIAL SECURITY NUMBER: 579-50-2941	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JUNE 16, 1916	8. BIRTHPLACE (State or Foreign Country): CUBA
9a. FACILITY NAME (If not institution, give street and number): 18705 THORNBERRY LANE			9b. CITY, TOWN OR LOCATION OF DEATH: OLNEY		9c. COUNTY OF OEATN: MONTGOMERY
RESIDENCE OF DECEDENT					
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: OLNEY			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 18705 THORNBERRY LANE		10f. ZIP CODE: 20832		10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS OECEDENT EVER IN U.S. ARMEO FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [X] YES 2 [ ] NO Specify: CUBAN			14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. OECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CONTRACTOR		16b. KIND OF BUSINESS/INDUSTRY: SELF EMPLOYED	
17. FATHER'S NAME (First, Middle, Last): RAMON MARTINEZ			18. MOTHER'S NAME (First, Middle, Maiden Surname): ANDREA MORFA		
19a. INFORMANT'S NAME (Type/Print): RAMON MARTINEZ		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18408 DUTCHESS DRIVE, OLNEY, MARYLAND 20832			
20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN MAUSOLEUM		20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 2090			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the dasth. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Dasth
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CARCINOMATOSIS	2 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	CARCINOMA OF COLON	4 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
OUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to dasth but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATN (Check only one) HOSPITAL: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA OTHER: 4 [ ] Nursing Nome 5 [X] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Nomicide 5 [ ] Pending investigation 8 [ ] Could not be datermined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. OESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.	29c. LICENSE NUMBER: D07469	29d. DATE SIGNED (Month, Day, Year) ▶ 8/25/89

30. NAME ANO ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT C. NOTHWANGER, M.D 106 IRVING ST. N.W. WASH. D.C. 20010

31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

15

89 25013

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD F. MULLIN			2. DATE OF DEATH (Month, Day, Year): AUGUST 22, 1989	3. TIME OF DEATH: 12:40 P M
4. SOCIAL SECURITY NUMBER: 214-28-4755	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): APRIL 19, 1914	8. BIRTHPLACE (State or Foreign Country): WASHINGTON, DC
9a. FACILITY NAME (If not institution, give street and number): MANOR CARE WHEATON		9b. CITY, TOWN OR LOCATION OF DEATH: WHEATON		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 2405 SUN VALLEY CIRCLE		10f. ZIP CODE: 20906	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): I	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): COMPUTER ANALYST	16b. KIND OF BUSINESS/INDUSTRY: GOVERNMENT PRINTING OFFICE
17. FATHER'S NAME (First, Middle, Last): FRANCIS S. MULLIN		18. MOTHER'S NAME (First, Middle, Maiden Surname): HELEN HESEN	
19a. INFORMANT'S NAME (Type/Print): KATHRYN MULLIN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2405 SUN VALLEY CIRCLE, SILVER SPRING, MARYLAND 20906	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FT. LINCOLN CEMETERY	20c. LOCATION — City or Town, State: BRENTWOOD, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael J Bigler		22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	PNEUMONIA	1 WEEK
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	ARTERIOSCLEROTIC CEREBROVASCULAR	
DUE TO (OR AS A CONSEQUENCE OF): c.	DISEASE	
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Walter E. Goozh MD	29c. LICENSE NUMBER: D001120	29d. DATE SIGNED (Month, Day, Year): 22 AUG 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): WALTER E. GOOZH 2309 SHOREFIELD ROAD, WHEATON, MARYLAND 20902

31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

10

89 25014

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph E. Mills
2. DATE OF DEATH (Month, Day, Year): August 17, 1989
3. TIME OF DEATH: 1:30 p. M
4. SOCIAL SECURITY NUMBER: 578-01-1290
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 82 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)
7. DATE OF BIRTH (Month, Day, Year): April 29, 1907
8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not institution, give street and number): 3202 Winnett Rd.
9b. CITY, TOWN OR LOCATION OF DEATH: Chevy Chase
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Chevy Chase
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3202 Winnett Rd.
10f. ZIP CODE: 20815
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Broker
16b. KIND OF BUSINESS/INDUSTRY: Meat Industry
17. FATHER'S NAME (First, Middle, Last): Joseph Mills
18. MOTHER'S NAME (First, Middle, Maiden Surname): Maybelle (Unknown)
19a. INFORMANT'S NAME (Type/Print): LILLIAN T. Mills
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as item # 10
20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cem.
20c. LOCATION — City or Town, State: Silver Spring, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leona Simmons
22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons, 5130 Wisconsin Av NW, Wash.,DC 20016

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiorespiratory Arrest	Sudden
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Carcinoma of Prostate	20 Years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Carcinoma of Lung
Arteriosclerotic Heart Disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John F. Gustafson M.D.
29c. LICENSE NUMBER: D15049
29d. DATE SIGNED (Month, Day, Year): ▶ August 18, 1989 (August 15, 1989)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John F. Gustafson, M.D., 5480 Wisconsin Ave., Chevy Chase, MD 20815-3595
31. DATE FILED (Month, Day, Year): AUG 23 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

10

89 25015

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT E. McMillian
2. DATE OF DEATH (Month, Day, Year): 08 25 89
3. TIME OF DEATH: 2025 P M
4. SOCIAL SECURITY NUMBER: 245-50-7441
6. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): 51 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 08 17 38
8. BIRTHPLACE (State or Foreign Country): No. Carolina
9a. FACILITY NAME (If not institution, give street and number): WASHINGTON ADVENTIST Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Silver Spring
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 8884 Piney Branch Road
10f. ZIP CODE: 20902
10g. CITIZEN OF WHAT COUNTRY?: U S A
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 1
16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Stockman
16b. KIND OF BUSINESS/INDUSTRY: Hospital
17. FATHER'S NAME (First, Middle, Last): Not available
18. MOTHER'S NAME (First, Middle, Maiden Surname): Katie Francis
19a. INFORMANT'S NAME (Type/Print): Jean Walton McMillian
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8884 Piney Branch Road S. S., Md., 20902
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glenwood Cemetery
20c. LOCATION — City or Town, State: Washington, D. C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: KENDALL BURNEY VANCIL — Kendall Burney Vancil
22. NAME AND ADDRESS OF FACILITY: Takoma Funeral Home, 254 Carroll St., N.W., Wash.,D.C.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac Arrest
OUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Cardiac Failure and
DUE TO (OR AS A CONSEQUENCE OF):
c. Renal Failure
OUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cerebrovascular accident with left Hemiplegia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MKarim MD
29c. LICENSE NUMBER: D-18895
29d. DATE SIGNED (Month, Day, Year): 8-26-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MOBARAK KARIM, 7610 Carroll Ave, Takoma Park, MD
31. DATE FILED (Month, Day, Year): AUG 29'89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25016
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MYRTLE PEACOCK McGONEGAL			2. DATE OF DEATH (Month, Day, Year): AUGUST 25, 1989	3. TIME OF DEATH: 5:03 PM M
4. SOCIAL SECURITY NUMBER: 220-44-3172	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JULY 12, 1897	8. BIRTHPLACE (State or Foreign Country): WASHINGTON, DC
9a. FACILITY NAME (If not institution, give street and number): CARRIAGE HILL-BETHESDA		9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: CHEVY CHASE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3715 CHEVY CHASE LAKE DRIVE		10f. ZIP CODE: 20815	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ELEMENTARY SCHOOL TEACHER	16b. KIND OF BUSINESS/INDUSTRY: DC PUBLIC SCHOOLS

17. FATHER'S NAME (First, Middle, Last): GEORGE COLUMBUS PEACOCK	18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH ANN TAYLOR	
19a. INFORMANT'S NAME (Type/Print): JOAN O. HORAN	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2611B PRICES DISTILLERY ROAD, CLARKSBURG, MD 20871	

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY	20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Douglas C. Sandell M00522	22. NAME AND ADDRESS OF FACILITY: ROBERT A. PUMPHREY FUNERAL HOME, BETHESDA-CHEVY CHASE, INC., 7557 WISCONSIN AVENUE, BETHESDA, MARYLAND 20814	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial failure DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John B. Umpson MD	29c. LICENSE NUMBER: D11024	29d. DATE SIGNED (Month, Day, Year): 8/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John B. Umpson MD 8505 Conn. Ave., Chevy Chase MD. 20815		
31. DATE FILED (Month, Day, Year): AUG 29'89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randell	

DHMH-16 Rev 1/89

10

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25017

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Susan Norton (Susan Norton)			2. DATE OF DEATH: MONTH 8 DAY 16 YEAR 89	3. TIME OF DEATH: 8:50 P M
4. SOCIAL SECURITY NUMBER: 579-60-2584	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 05/03/02	8. BIRTHPLACE (State or Foreign Country): Italy
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Washington, DC	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1227 31st St. NW		10f. ZIP CODE: 20007	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None	16b. KIND OF BUSINESS/INDUSTRY: None
17. FATHER'S NAME (First, Middle, Last): Richard Norton		18. MOTHER'S NAME (First, Middle, Maiden Surname): Edith White	
19a. INFORMANT'S NAME (Type/Print): Susan Ringland		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6801 West Av., Chevy Chase, MD 20815	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Comfort Crematory	20c. LOCATION — City or Town, State: Alexandria, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael C. Nelson		22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons 5130 Wisconsin Av NW, Washington, DC 20016	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio Respiratory Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary Arteriosclerosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Gruber MD	29c. LICENSE NUMBER: D08546	29d. DATE SIGNED (Month, Day, Year) ▶ 8-17-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Gruber MD 8218 Wisconsin Ave Bethesda md		
31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

89 25018

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John T. O'Neil, III		2. DATE OF DEATH (Month, Day, Year): 8-13-89	3. TIME OF DEATH: 5:30PM M
4. SOCIAL SECURITY NUMBER: 146-68-1031	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 23 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1/31/66
8. BIRTHPLACE (State or Foreign Country): New Jersey			
9a. FACILITY NAME (If not institution, give street end number): Metro Station	9b. CITY, TOWN OR LOCATION OF DEATH: Rockville	9c. COUNTY OF DEATH: Montgomery County	

RESIDENCE OF DECEDENT

10a. STATE: N. J.	10b. COUNTY: Mercer	10c. CITY, TOWN OR LOCATION: Princeton Township	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 124 Heather Lane	10f. ZIP CODE: 08540	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): John T. O'Neil, Jr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Jacqueline Meier	
19a. INFORMANT'S NAME (Type/Print): John T. O'Neil, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 124 Heather Lane, Princeton, New Jersey 08540	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Princeton Cemetery	20c. LOCATION — City or Town, State: Princeton, New Jersey
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Gary L. Kaufman Funeral Homes 5695 Main Street, Elkridge, Md. 21227	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? XXX YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence XXX Other (Specify) Scene		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident XXX Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-13-89	28b. TIME OF INJURY: 5:20PM	28c. INJURY AT WORK? 1 [ ] YES XX NO
	28d. DESCRIBE HOW INJURY OCCURED: Subject jumped into front of train		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): platform	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Metro Station, Rockville, Montgomery County, Maryland	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 8-14-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201		VC
31. DATE FILED (Month, Day, Year): AUG 16 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25019
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dorothy Marie Allen Oberdick

2. DATE OF DEATH (Month, Day, Year): August 23, 1989

3. TIME OF DEATH: 3:37 pM

4. SOCIAL SECURITY NUMBER: 219-54-5350

5. SEX: 1 ☐ M 2 ☐ F XX

6. AGE (In yrs. last birthday): 73 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): March 16, 1916

8. BIRTHPLACE (State or Foreign Country): Pennsylvania

9a. FACILITY NAME (If not institution, give street and number): Montgomery General Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Olney, Md.

9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Silver Spring

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ ND

10e. STREET AND NUMBER: 3273 S. Leisure World Blvd.

10f. ZIP CODE: 20906

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ ND — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 1-12
College (1-4 or 5+): College

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Registered Nurse

16b. KIND OF BUSINESS/INDUSTRY: Nursing

17. FATHER'S NAME (First, Middle, Last): William Allen

18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma P. Larden

19a. INFORMANT'S NAME (Type/Print): James Allen Oberdick

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3273 S. Leisure World Blvd., S.S. Md. 20906

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

20c. LOCATION — City or Town, State: Silver Spring, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]

22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home
11800 N.H. Ave. Silver Spring, Md. 20904

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Hemopericardium	Minutes
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Dissecting aortic aneurysm	Hours
DUE TO (OR AS A CONSEQUENCE OF):	—	
c.		
DUE TO (OR AS A CONSEQUENCE OF):	—	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: —

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ ND

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ ND

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Joan R Kumar MD

29c. LICENSE NUMBER: D30868

29d. DATE SIGNED (Month, Day, Year): Aug 24, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joan R Kumar, M.D. Pathologist, Montgomery General Hospital

31. DATE FILED (Month, Day, Year): AUG 25 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

24

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25020
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ERNEST L. PLUMMER					2. DATE OF DEATH (Month, Day, Year): 8 25 89	3. TIME OF DEATH: 1120 AM
4. SOCIAL SECURITY NUMBER: 217-34-0500	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 52 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Mar 9, 1937	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Damascus	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 10610 Shasta Court		10f. ZIP CODE: 20872	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer	16b. KIND OF BUSINESS/INDUSTRY: Landscape	
17. FATHER'S NAME (First, Middle, Last): Howard Plummer		18. MOTHER'S NAME (First, Middle, Maiden Surname): Maude E. Jackson	
19a. INFORMANT'S NAME (Type/Print): Ms Anna Mae Smith	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10610 Shasta Ct, Damascus, Md #20872		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): John Wesley Cemetery	20c. LOCATION — City or Town, State: Clarksburg, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George L. Snowden	22. NAME AND ADDRESS OF FACILITY: Snowden Funeral Home #20850, 246 N. Washington St, Rockville, Md		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. GASTRO INTESTINAL HEMORRHAGE-	72 Hours
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ADENOCARCINOMA PANCREAS AND STOMACH	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS
BILIARY OBSTRUCTION

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph J. Kennedy MD.	29c. LICENSE NUMBER: D35087	29d. DATE SIGNED (Month, Day, Year): ▶ 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 15225 SHADY GROVE ROAD, ROCKVILLE, MD. 20850

31. DATE FILED (Month, Day, Year): AUG 29'89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

6

89 25021

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELISABETH A. PARROTT
2. DATE OF DEATH: MONTH 8 DAY 22 YEAR 89
3. TIME OF DEATH: 2:30 p.m.
4. SOCIAL SECURITY NUMBER: 577 60 7001
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3/3/04
8. BIRTHPLACE (State or Foreign Country): Wash. D.C.

9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring MD
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Kensington MD.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 10802 Stella Court MD
10f. ZIP CODE: 20895
10g. CITIZEN OF WHAT COUNTRY? USA.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk
16b. KIND OF BUSINESS/INDUSTRY: U.S. Govt.

17. FATHER'S NAME (First, Middle, Last): Samuel William Thomas Comer
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa Fretwell

19a. INFORMANT'S NAME (Type/Print): Patricia A. Parrott
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10802 Stella Crt. Kensington, MD. 20895

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Chambers Crematory
20c. LOCATION — City or Town, State: Riverdale, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas S. Chambers # 670
22. NAME AND ADDRESS OF FACILITY: W.W. Chambers Co. Inc. 9241 Columbia Blvd. Silver Spring, MD. 20910

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest — 1 Hour

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ABDOMINAL Catastrophy - possible

DUE TO (OR AS A CONSEQUENCE OF):

c. duodenum.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Penny L Bush MD.
29c. LICENSE NUMBER: D25085
29d. DATE SIGNED (Month, Day, Year): 8/22/89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 10313 Georgia Ave Silver Spring MD. 20910

31. DATE FILED (Month, Day, Year): AUG 25 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25022

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph W. Redding / Joseph W. Redding			2. DATE OF DEATH: MONTH 8 DAY 22 YEAR 89	3. TIME OF DEATH: 11 30 P.M
4. SOCIAL SECURITY NUMBER: 220-05-8211	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Dec. 12, 1915
8. BIRTHPLACE (State or Foreign Country): Kansas				

9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda	9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Bethesda	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9909 Derbyshire Lane	10f. ZIP CODE: 20817	10g. CITIZEN OF WHAT COUNTRY? U. S. A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO; IF YES, GIVE WAR OR DATES: World War II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chief of Communications	16b. KIND OF BUSINESS/INDUSTRY: Defense Logistics Agency	
17. FATHER'S NAME (First, Middle, Last): Joseph C. Redding	18. MOTHER'S NAME (First, Middle, Maiden Surname): Lyda K. Covert		
19a. INFORMANT'S NAME (Type/Print): Katherine Redding	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9909 Derbyshire Ln., Bethesda, MD 20817		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery	20c. LOCATION — City or Town, State: Arlington, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vernon Simmons	22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons, Inc. 5130 Wisconsin Av., Washington, DC 20016		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pneumonia, Pseudomonas aeruginosa	4 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	Asthmatic Bronchitis	5 months
c. DUE TO (OR AS A CONSEQUENCE OF):	Adenocarcinoma of (R) lung	5 months
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Lee R. Pennington MD	29c. LICENSE NUMBER: D21115	29d. DATE SIGNED (Month, Day, Year) ▶ 8/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lee R. Pennington, M.D. 11500 Old Georgetown Rd. Rockville, Md 20852

31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-18 Rev 1/89

6

89 25023

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen Rubinson Helen Rubinson			2. DATE OF DEATH: MONTH 8 DAY 25 YEAR 89	3. TIME OF DEATH: 1034 P M
4. SOCIAL SECURITY NUMBER: 052-09-4732	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 8, 1915	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1202 Princeton Place		10f. ZIP CODE: 20850		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bookkeeper		16b. KIND OF BUSINESS/INDUSTRY: City of New York
17. FATHER'S NAME (First, Middle, Last): Isaac Cohen			18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Kaminetsky	
19a. INFORMANT'S NAME (Type/Print): Gene Rubinson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1202 Princeton Place, Rockville, MD 20850		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Beth David Cemetery		20c. LOCATION — City or Town, State: Elmont, New York
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellen W. Rapp		22. NAME AND ADDRESS OF FACILITY: Gutterman's, Inc. 175 Long Beach Road, Rockville Centre, NY 11570		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Breast cancer - probably metastatic
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Hydrocephalus
DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic Active Hepatitis
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.: Pleural effusions

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Philip Schwartz Philip Schwartz	29c. LICENSE NUMBER: 024398 - MARYLAND	29d. DATE SIGNED (Month, Day, Year): ▶ 8-26-89	11A
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 15225 Shady Grove Rd Suite 206 Rockville, MD 20850			
31. DATE FILED (Month, Day, Year): AUG 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

OHMH-16 Rev 1/89

4

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25024

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Leida Raudkivi				2. DATE OF DEATH (Month, Day, Year): 8 / 10 / 89	3. TIME OF DEATH: 1926 PM
4. SOCIAL SECURITY NUMBER: 314-30-5947	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5-24-1903	8. BIRTHPLACE (State or Foreign Country): ESTONIA
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adventist Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY CO.
RESIDENCE OF DECEDENT					
10a. STATE: MD.	10b. COUNTY: PRINCE GEORGES CO.	10c. CITY, TOWN OR LOCATION: COLLEGE PARK			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9014- RHODE ISLAND AVENUE			10f. ZIP CODE: 20770		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY: UNKNOWN	
17. FATHER'S NAME (First, Middle, Last): KAAREL NURK			18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIE BUSCH		
19a. INFORMANT'S NAME (Type/Print): REV.DR.REICHARD			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9701-VEIRS DR.,ROCKVILLE,MD. 20850		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEMETERY		20c. LOCATION — City or Town, State: BALTIMORE,MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W. M. Hysong			22. NAME AND ADDRESS OF FACILITY: HYSONG COMPANY,INC. 1300-N ST.,NW WASH.,DC 20005		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebral Arterio Sclerosis	Years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas E. Dooley, MD	29c. LICENSE NUMBER: D16455	29d. DATE SIGNED (Month, Day, Year) ▶ August 19, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas E. Dooley, MD 17904 Georgia Avenue Olney MD 20832		
31. DATE FILED (Month, Day, Year): AUG 23'89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25025 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B 3

4

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Martin R. Segovia				2. DATE OF DEATH (Month, Day, Year): 08 28 89	3. TIME OF DEATH: 1830 M
4. SOCIAL SECURITY NUMBER: 216-11-6041	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 32 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 08-18-57	8. BIRTHPLACE (State or Foreign Country): El Salvador
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hosp.		9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park			9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT					
10a. STATE: Md.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Takoma Park			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 8706 Gilbert Place		10f. ZIP CODE: 20912			10g. CITIZEN OF WHAT COUNTRY?: El Salvador
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] YES 2 [ ] NO Specify: El Salvadorian			14. RACE — American Indian, Black, White, etc. Specify: Hispanic
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Painter		16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Guan Antonio Quintilla				18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa Segovia	
19a. INFORMANT'S NAME (Type/Print): Oscar Segovia		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8706 Gilbert Place Takoma Park Md 20912			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Family Cemetery		20c. LOCATION — City or Town, State: San Miguel El Salvador	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. H. Bacon		22. NAME AND ADDRESS OF FACILITY: W. H. Bacon Funeral Home 3447 14th Street, N.W.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	
DUE TO (OR AS A CONSEQUENCE OF):	b. Septic Shock	3
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. Metabolic Acidosis	3
DUE TO (OR AS A CONSEQUENCE OF):	d. Alcohol Toxicity	13

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alcoholism

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
R. Ashby MD Attending Phys	D 31326	8/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard B. Ashby MD 8580 Second Avenue, Silver Spring, MD.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 '89	Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25026
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD SWEET			2. DATE OF DEATH (Month, Day, Year): August 22, 1989	3. TIME OF DEATH: 10:15 p.M
4. SOCIAL SECURITY NUMBER: 011-12-3821	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 72 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 4/11/1917	8. BIRTHPLACE (State or Foreign Country): Massachusetts
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 11118 Easecrest Drive	10f. ZIP CODE: 20902		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XX YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Business Owner (Retired)	16b. KIND OF BUSINESS/INDUSTRY: SLATE FURNITURE	
17. FATHER'S NAME (First, Middle, Last): David Sweet		18. MOTHER'S NAME (First, Middle, Maiden Surname): Molly Wilkens	
19a. INFORMANT'S NAME (Type/Print): Sylvia Sweet (Wife)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11118 Easecrest Drive; Silver Spring, Md. 20902		
20a. METHOD OF DISPOSITION: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King David Memorial Garden	20c. LOCATION — City or Town, State: Falls Church, Va.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Carl A Stone	22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike; Rockville, Md 20852		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory failure	minutes
DUE TO (OR AS A CONSEQUENCE OF): b.	Shock	6 hrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Irreversible coma	3 wks
d.	Brain tumor	1 yr.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard Delaney Md	29c. LICENSE NUMBER: D 02338	29d. DATE SIGNED (Month, Day, Year): ▶ 8/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD P. DELANEY, M.D. 4523 HAVARD ST, SILVER SPRING, MD 20906

31. DATE FILED (Month, Day, Year): AUG 23 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

12

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25027
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna Schroeder				2. DATE OF DEATH: MONTH 8 DAY 11 YEAR 89	3. TIME OF DEATH: 9:42 P M
4. SOCIAL SECURITY NUMBER: 216-05-8327	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)		7. DATE OF BIRTH (Month, Day, Year): 3/10/97	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SGAH -SHADY GROVE HOSP.		9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY CO.	
RESIDENCE OF DECEDENT					
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE CITY	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 312-S. CALHOUN STREET		10f. ZIP CODE: 21223		10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLERK		16b. KIND OF BUSINESS/INDUSTRY: UNKNOWN	
17. FATHER'S NAME (First, Middle, Last): JACOB J. SCHROEDER		18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE EVA KELLER			
19a. INFORMANT'S NAME (Type/Print): REV.DR.REICHARD		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9701-VEIRS DR.,ROCKVILLE,MD. 20850			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DRUID RIDGE CEMETERY		20c. LOCATION — City or Town, State: BALTIMORE,MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W. Th. Hysong		22. NAME AND ADDRESS OF FACILITY: HYSONG CO.,INC. 1300-N ST.,NW WASH.,DC			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardio respiratory Arrest	Immediate
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Prob Sclk Hy. cardiol Infarct	90 mi
DUE TO (OR AS A CONSEQUENCE OF):		
c.	ASHD with Cong Heart Failure	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Adeno carcin of Colon
Chronic Idio pulm Fibrosis
Pyelonephritis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Edward J Davis MD	D33677	▶ 8/11/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward J Davis, MD 19721 Executive Park Circle Germantown MD 20874

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
~~8/11/89~~ AUG 23 '89	Julia Davidson-Randall

OHMH-16 Rev 1/89

89 25028

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM OZZIE SMOOT (William O Smoot)		2. DATE OF DEATH (Month, Day, Year): 8 24 89	3. TIME OF DEATH: 0045 A M
4. SOCIAL SECURITY NUMBER: 217-30-2284 (217-30-2284)	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 66 (66) YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JAN. 22, 1923
8. BIRTHPLACE (State or Foreign Country): MARYLAND			
9a. FACILITY NAME (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL (Washington Adventist Hospital)	9b. CITY, TOWN OR LOCATION OF DEATH: TAKOMA PARK (Takoma Park)	9c. COUNTY OF DEATH: MONTGOMERY (MONTGOMERY)	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: CHARLES	10c. CITY, TOWN OR LOCATION: WALDORF	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2011 C WEDGEWOOD PLACE		10f. ZIP CODE: 20601	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 10TH GRADE	College (1-4 or 5+): NONE	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FARMER	16b. KIND OF BUSINESS/INDUSTRY: FARMING
17. FATHER'S NAME (First, Middle, Last): MARION SMOOT		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH HAWKINS	
19a. INFORMANT'S NAME (Type/Print): VERONICA E. MATTHEWS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2119 ALICE AVENUE #203 OXON HILL, MARYLAND 20745	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. JOSEPH'S CHURCH CEMETERY	20c. LOCATION — City or Town, State: POMFRET, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lydia C. Thornton Johnson		22. NAME AND ADDRESS OF FACILITY: THORNTON'S FUNERAL HOME POMONKEY, MARYLAND 20640	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CARDIO RESPIRATORY ARREST	
DUE TO (OR AS A CONSEQUENCE OF): b.	CORONARY ARTERY DISEASE	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John L. Jones MD	29c. LICENSE NUMBER: D-31572	29d. DATE SIGNED (Month, Day, Year): 8/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN L. JONES MD. 7610 CARROLL AVE, TAKOMA PARK, MD. 20912		
31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

5

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25029

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): Juanita Vande Sande					2. DATE OF DEATH: MONTH 8 DAY 21 YEAR 1989	3. TIME OF DEATH: 10:47 A. M
4. SOCIAL SECURITY NUMBER: 057-30-2585	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 52 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 25, 1937	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): 8420 Comanche Court			9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda		9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Montgomery		10c. CITY, TOWN OR LOCATION: Bethesda		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 8420 Comanche Court			10f. ZIP CODE: 20817		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS OECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12	College (1-4 or 5+): n/a		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Mario G. Mostard			18. MOTHER'S NAME (First, Middle, Maiden Surname): Mildred Carieri			
19a. INFORMANT'S NAME (Type/Print): George Vande Sande			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as item # 10			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rockville Cem.		20c. LOCATION — City or Town, State: Rockville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Vernon [signature]			22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC SARCOMA	4 YRS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: D29675

29d. DATE SIGNED (Month, Day, Year): 8/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ralph V. Boccia, 14800 Physicians Lane, Rockville, MD. 20850

31. DATE FILED (Month, Day, Year): AUG 25 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

Items:23,27 per ME G-657
11-29-89 cm

89 25030

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Michelle	Diane	Sheffler	8-28-89	9:35AM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
	1 ☐ M 2 ☒ F	30 YRS.			July 11,1959	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
19427 Brassie Place	Gaithersburg	Montgomery County

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Montgomery	Gaithersburg	1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
19427 Brassie Place	20879	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12	2	computer operator	fed. gov't

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Kenneth Sheffler	Betty Mulhern

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kenneth Sheffler	255 Wilkson Lane, Fayetteville, Pa. 17222

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Rose Hill Cemetery	Clear Spring, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Scott Minnick	MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrhythmia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Myocardial fibrosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Von Recklinghausen's Disease

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
XXX 1 ☒ YES 2 ☐ NO	XXX 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
XXX 1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home XXX 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Mario F. Golle Jr. M.D.	OCME	▶ 8-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Mario F. Golle,Jr.,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
SEP 5 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25031

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen E. Trenchi
2. DATE OF DEATH (Month, Day, Year): August 23, 1989
3. TIME OF DEATH: 12:10 P M
4. SOCIAL SECURITY NUMBER: 578-10-8979
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12/16/1910
8. BIRTHPLACE (State or Foreign Country): Washington D.C.
9a. FACILITY NAME (If not institution, give street and number): 1709 Wilmart St.
9b. CITY, TOWN OR LOCATION OF DEATH: Rockville
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Rockville
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1709 Wilmart St.
10f. ZIP CODE: 20852
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ------ ; College (1-4 or 5+): 5+
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales
16b. KIND OF BUSINESS/INDUSTRY: Real Estate
17. FATHER'S NAME (First, Middle, Last): Harry I. Coxen
18. MOTHER'S NAME (First, Middle, Maiden Surname): Myrtle Bradley
19a. INFORMANT'S NAME (Type/Print): Edward A. Trenchi
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1709 Wilmart St. Rockville, MD. 20852
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Chambers Crematory
20c. LOCATION — City or Town, State: Riverdale, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas S. Chambers # 670
22. NAME AND ADDRESS OF FACILITY: W.W.Chambers Co. Inc. 9241 Columbia Blvd. Silver Spring, MD. 20910

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardio Pulmonary Arrest	
DUE TO (OR AS A CONSEQUENCE OF): b.	Metastatic Colon Cancer	6mo
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Large Bowel Obstruction	3wks
d.	Atrial fibrillation.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: N/A M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED: N/A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Brendan D Curtis MD
29c. LICENSE NUMBER: MD Lic: D33760
29d. DATE SIGNED (Month, Day, Year): ▶ 8/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Brendan D. Curtis Georgetown University Hospital, 3300 Reservoir Rd NW Washington D.C. 2007
31. DATE FILED (Month, Day, Year): AUG 25 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randello

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25032
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MIHALY VARGA		2. DATE OF DEATH (Month, Day, Year): August 22, 1989	3. TIME OF DEATH: 9:15 AM
4. SOCIAL SECURITY NUMBER: 216-17-6937	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 52 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7/29/37
8. BIRTHPLACE (State or Foreign Country): HUNGARY			
9a. FACILITY NAME (If not institution, give street and number): HOME - 9424 COLLETTE WAY	9b. CITY, TOWN OR LOCATION OF DEATH: GAITHERSBURG	9c. COUNTY OF DEATH: MONTGOMERY	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Gaithersburg	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 9424 Collette Way	10f. ZIP CODE: 20879	10g. CITIZEN OF WHAT COUNTRY?: Hungary	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 12	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chauffeur	16b. KIND OF BUSINESS/INDUSTRY: Moving

17. FATHER'S NAME (First, Middle, Last): Mihaly Varga	18. MOTHER'S NAME (First, Middle, Maiden Surname): Erzsebet Nagy
19a. INFORMANT'S NAME (Type/Print): Maria Varga	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory	20c. LOCATION — City or Town, State: Alexandria, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, Maryland 20877	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. LUNG CANCER	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CIGARETTE SMOKING	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ESOPHAGEAL OBSTRUCTION FROM EXTENSION OF CANCER

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Alan S. Chanales M.D.	29c. LICENSE NUMBER: 29453	29d. DATE SIGNED (Month, Day, Year) ▶ 8/22/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALAN S. CHANALES 15225 SHADY GROVE RD ROCKVILLE MD 20902		
31. DATE FILED (Month, Day, Year): AUG 24 89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

3

DHMH-16 Rev 1/89

89 25033

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marjorie Evelyn Wallace			2. DATE OF DEATH (Month, Day, Year): August 21, 1989	3. TIME OF DEATH: 2:15 PM M
4. SOCIAL SECURITY NUMBER: 114-10-5343	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 26, 1918	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): 1619 Tweed Street		9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1619 Tweed Street		10f. ZIP CODE: 20851		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Joseph La Valley		18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Knickerbocker		
19a. INFORMANT'S NAME (Type/Print): Lee E. Wallace		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1619 Tweed Street, Rockville, Maryland 20851		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rockville Cemetery		20c. LOCATION — City or Town, State: Rockville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Barbara Jo McMullen Lawrence M00381		22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Carcinoma	9 month
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Adenosquamous Carcinoma of Lung	2 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Eugene P. Libre MD	D 09470	▶ August 22, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Eugene P. Libre, M.D., 10400 Connecticut Avenue, Kensington, Maryland 20895

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 24 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25034

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marian A. Williams

2. DATE OF DEATH (Month, Day, Year): 8/13/89

3. TIME OF DEATH: 1:40 PM M

4. SOCIAL SECURITY NUMBER: 216-32-2423A

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 84 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): X 2/23/1905

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): NATIONAL LUTHERAN HOME

9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE

9c. COUNTY OF DEATH: MONTGOMERY CO.

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: BALTIMORE CITY

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 204- BLENHEIM ROAD

10f. ZIP CODE: 21212

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLERK

16b. KIND OF BUSINESS/INDUSTRY: UNKNOWN

17. FATHER'S NAME (First, Middle, Last): WILLIAM H. BOLANDER

18. MOTHER'S NAME (First, Middle, Maiden Surname): IDA V. BOLANDER

19a. INFORMANT'S NAME (Type/Print): REV.DR. REICHARD

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9701-VEIRS DR.,ROCKVILLE,MD. 20850

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY

20c. LOCATION — City or Town, State: BALTIMORE,MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William M. Hysong

22. NAME AND ADDRESS OF FACILITY: HYSONG CO.,INC.
1300-N ST.,NW WASH.,DC 20005

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardio respiratory Arrest	0
DUE TO (OR AS A CONSEQUENCE OF): b.	Pulmonary Edema	5 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Myocardial Infarction on 8 August 89	5 days
d.	Myocardial Infarction on 28 July 89	16 days

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Acute Gastro intestinal Bleed 28 July 89
Severe Organic Brain Syndrom

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edward J Davin

29c. LICENSE NUMBER: D33677

29d. DATE SIGNED (Month, Day, Year): ▶ 8/13/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward J Davin, M.D. 19721 Executive Park Circle Germantown MD 20874

31. DATE FILED (Month, Day, Year): AUG 23 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25035 REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) JUSTIN JONG YOU		2. DATE OF DEATH Month: 8 Day: 20 Year: 89	3. TIME OF DEATH 4:35 PM
4. SOCIAL SECURITY NUMBER 229-08-7193	5. SEX 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday) 56 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) 12/28/32
8. BIRTHPLACE (State or Foreign Country) Korea			
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital / WASHINGTON ADVENTIST HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park / TAKOMA PARK, MD.	9c. COUNTY OF DEATH Montgomery / MONTGOMERY	

RESIDENCE OF DECEDENT

10a. STATE Maryland / MARYLAND	10b. COUNTY Montgomery / MONTGOMERY	10c. CITY, TOWN OR LOCATION Silver Spring / SILVER SPRING	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER 13105 Hutchinson Way	10f. ZIP CODE 20906	10g. CITIZEN OF WHAT COUNTRY? USA	

11. MARITAL STATUS 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Korean

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 1-12 / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Merchant	16b. KIND OF BUSINESS/INDUSTRY Self employed	
17. FATHER'S NAME (First, Middle, Last) Suk-Hwa You	18. MOTHER'S NAME (First, Middle, Maiden Surname) Yong Jun Won		
19a. INFORMANT'S NAME (Type/Print) Bonnie Lee You	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13105 Hutchinson Way, Silver Spring, Md. 20906		
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GAte of Heaven Cemetery	20c. LOCATION — City or Town, State Silver Spring, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ [signature]	22. NAME AND ADDRESS OF FACILITY Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. 20904		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Bleeding	24 hours
DUE TO (OR AS A CONSEQUENCE OF):	b. cardiovascular surgery	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. aortic aneurysm, aortic valve disease 2 yrs	
DUE TO (OR AS A CONSEQUENCE OF):	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☑ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Joann Orgurath	29c. LICENSE NUMBER D 25881	29d. DATE SIGNED (Month, Day, Year) ▶ 8/21/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9711 Medical Center Dr. Rockville, Md. / 9711 Medical Center Dr Rockville md		
31. DATE FILED (Month, Day, Year) AUG 25 '89	32. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 25036

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALBERT ERNEST YOWELL, JR.
2. DATE OF DEATH — MONTH / DAY / YEAR: 08-21-89
3. TIME OF DEATH: 9:00 P M
4. SOCIAL SECURITY NUMBER: 579-38-5357
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 56 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12/09/32
8. BIRTHPLACE (State or Foreign Country): WASHINGTON, DC
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Silver Spring
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 322 Highview Place
10f. ZIP CODE: 20901
10g. CITIZEN OF WHAT COUNTRY? USA United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: KOREA
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 1
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Police officer
16b. KIND OF BUSINESS/INDUSTRY: D.C. POLICE DEPARTMENT
17. FATHER'S NAME (First, Middle, Last): ALBERT E. YOWELL, SR.
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY CLINE
19a. INFORMANT'S NAME (Type/Print): ANNE M. YOWELL
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 322 HIGHVIEW PLACE, SILVER SPRING, MARYLAND 20901
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN
20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Metastatic Small Cell Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Anemia
Thrombocytopenia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Peter Sherer MD
29c. LICENSE NUMBER: D21910
29d. DATE SIGNED (Month, Day, Year): 8/22/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Peter Sherer MD 3947 Ferrara Dr. Wheaton, md 20906
31. DATE FILED (Month, Day, Year): AUG 25'89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

20+1

89 25039

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Louise Branch			2. DATE OF DEATH (Month, Day, Year): 8-16-89	3. TIME OF DEATH: 12:14AM M
4. SOCIAL SECURITY NUMBER: 230 02 4902	5. SEX: 1 ☐ M 2 ☒ F	8. AGE (In yrs. last birthday): 25 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 06/29/'64	8. BIRTHPLACE (State or Foreign Country): Washington DC
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Clinton		9c. COUNTY OF DEATH: Prince Georges Co.

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: Malcolm	10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: Post Office Box 163		10f. ZIP CODE: 20613	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): n/a	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Johnny Earl Branch		18. MOTHER'S NAME (First, Middle, Maiden Surname): Hazel E. Reed	
19a. INFORMANT'S NAME (Type/Print): Hazel E. Reed		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 163, Brandywine, Maryland 20613	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Washington National Cem	20c. LOCATION — City or Town, State: Suitland, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mastell Adams		22. NAME AND ADDRESS OF FACILITY: Adams Funeral Home, P.A. Aquasco Road, Aquasco MD. 20608	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Thoracic Injuries

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-15-89	28b. TIME OF INJURY: 11:50PM	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road		28d. DESCRIBE HOW INJURY OCCURED: Pedestrian struck by auto
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1700 blk. Horseshead Rd. Brandywine, Prince Georges Co., MD

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 8-16-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn Street, Baltimore, MD 21201		VC
31. DATE FILED (Month, Day, Year): AUG 23 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randolph	

DHMH-18 Rev 1/89

89 25037

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Adrian Arbiza		2. DATE OF DEATH (Month, Day, Year): 8-12-89	3. TIME OF DEATH: 12:18AM M
4. SOCIAL SECURITY NUMBER: NONE	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 53 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-28-35
8. BIRTHPLACE (State or Foreign Country)			
9a. FACILITY NAME (If not institution, give street and number): 1300 Blk. University Blvd.	9b. CITY, TOWN OR LOCATION OF DEATH: Hyattsville	9c. COUNTY OF DEATH: Prince Georges Co.	
RESIDENCE OF DECEDENT			
10a. STATE: MD.	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 8137 15th AVE.	10f. ZIP CODE: 20783	10g. CITIZEN OF WHAT COUNTRY? CENTRAL AMERICA	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] YES 2 [ ] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: HISPANIC
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4 ELM. College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABOR	16b. KIND OF BUSINESS/INDUSTRY: CONSTRUCTION	
17. FATHER'S NAME (First, Middle, Last): SILBERRO ROMERO	18. MOTHER'S NAME (First, Middle, Maiden Surname): LANNIA ARBAIZA		
19a. INFORMANT'S NAME (Type/Print): JOSA SANCHZ	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8137 15th AVE. SILVER SPRING MD. 20783		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DELAIAS DE CONUPCION	20c. LOCATION — City or Town, State: MORAZAN CENTRAL AMERICA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] 702	22. NAME AND ADDRESS OF FACILITY: 4804 GA. AVE. N.W. / VANN & WM. F.H.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. DUE TO (OR AS A CONSEQUENCE OF):	
	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Chronic alcoholism

24a. WAS AN AUTOPSY PERFORMED? [XX] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [XX] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [XX] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [XX] Other (Specify) Scene/Street

27. MANNER OF DEATH: 1 [ ] Natural [XX] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 8-12-89

28b. TIME OF INJURY: 12:12AM

28c. INJURY AT WORK? 1 [ ] YES 2 [XX] NO

28d. DESCRIBE HOW INJURY OCCURED: Pedestrian struck by auto

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Street

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1300 Blk. University Blvd. Hyattsville, Prince Georges Co.MD

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [XX] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): ▶ 8-12-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. KOkes,M.D. 111 Penn Street,Balto.,MD 21201

REISSUED: 8-16-89 VC

31. DATE FILED (Month, Day, Year): AUG 17 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

(3)

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25038

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY SUE ANDERSON				2. DATE OF DEATH (Month, Day, Year): 8/17/1989	3. TIME OF DEATH: 2:55 P M
4. SOCIAL SECURITY NUMBER: 579-58-6050	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Dec. 25, 1913	8. BIRTHPLACE (State or Foreign Country): Georgia
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital Center			9b. CITY, TOWN OR LOCATION OF DEATH: Clinton		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: Waldorf	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3225 Indian King Court		10f. ZIP CODE: 20601	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker	16b. KIND OF BUSINESS/INDUSTRY: home
17. FATHER'S NAME (First, Middle, Last): William F. Donaldson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances M. Dunnegan	
19a. INFORMANT'S NAME (Type/Print): Thomas E. Anderson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1105 East Patuxent Dr., LaPlata, MD 20646	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery	20c. LOCATION — City or Town, State: Brentwood, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeanne L Bates		22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd., Clinton, MD 20735	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. RESPIRATORY ARREST.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. SEVERE EMPHYSEMA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
- CORONARY ARTERY DISEASE
- CHRONIC PANCREATITIS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S. K. Mishra MD	29c. LICENSE NUMBER: D23021	29d. DATE SIGNED (Month, Day, Year): 8/17/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): In Dr's. Office. Charles Prof. Center #508, Waldorf, Md 20601

31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall AUG 25 '89

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25040 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Bernard John Brockmeyer
2. DATE OF DEATH (Month, Day, Year): Aug 24 89
3. TIME OF DEATH: 4:30 PM
4. SOCIAL SECURITY NUMBER: 219-14-1767
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 63 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1-24-26
8. BIRTHPLACE (State or Foreign Country): Baltimore, MD
9a. FACILITY NAME (If not institution, give street and number): 14609 Shiloh Ct
9b. CITY, TOWN OR LOCATION OF DEATH: Laurel
9c. COUNTY OF DEATH: Prince George

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George
10c. CITY, TOWN OR LOCATION: Laurel
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 14609 Shiloh Court Apt. X3
10f. ZIP CODE: 20708
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: WW II
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Permit Processor
16b. KIND OF BUSINESS/INDUSTRY: Self-Employed
17. FATHER'S NAME (First, Middle, Last): Joseph Brockmeyer
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Geisler
19a. INFORMANT'S NAME (Type/Print): Nettie L. Brockmeyer
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14609 Shiloh Court Apt. X3 Laurel, MD 20708
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crownsville Md Veterans Cem
20c. LOCATION — City or Town, State: Crownsville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Natalie Gilbert 759
22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, MD 20707

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Dis
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Chronic Myocardial Dis
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. LICENSE NUMBER: D09275
29d. DATE SIGNED (Month, Day, Year): Aug 24, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): AUG 29 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25041
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Doris Elizabeth BENDER					2. DATE OF DEATH (Month, Day, Year): 08 / 25 / 89	3. TIME OF DEATH: 8:25 a M
4. SOCIAL SECURITY NUMBER: 578-34-1778	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan 31 1921	8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): AMI DRS' HOSPITAL OF PG COUNTY			9b. CITY, TOWN OR LOCATION OF DEATH: Lanham		9c. COUNTY OF DEATH: Prince Georges	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Prince Georges		10c. CITY, TOWN OR LOCATION: Seabrook		10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO	
10e. STREET AND NUMBER: 9519 Franklin Avenue			10f. ZIP CODE: 20706		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Cauc.	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5+): 0			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Leo T. Quigley			18. MOTHER'S NAME (First, Middle, Maiden Surname): Beulah Wannall			
19a. INFORMANT'S NAME (Type/Print): Philip F. Bender			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9519 Franklin Ave. Seabrook, Maryland 20706			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery		20c. LOCATION — City or Town, State: Washington, D.C.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard Rendon			22. NAME AND ADDRESS OF FACILITY: Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic Myocardial Disease DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John Rogers M.D.	D08915	Aug 25, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Rogers M.D. 1919 Seminary Road Silver Spring, Maryland

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 30 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

4

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25042

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be typed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last): William H Bishop				2. DATE OF DEATH (Month - Day - Year): 8 - 15 - 89	3. TIME OF DEATH: 12 53P M
4. SOCIAL SECURITY NUMBER: 085-03-3755	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 20, 1907	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Clinton		9c. COUNTY OF DEATH: Prince Georges	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Clinton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4422 Natahala Dr.		10f. ZIP CODE: 20735	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): salesperson	16b. KIND OF BUSINESS/INDUSTRY: Lord & Taylor - retail	
17. FATHER'S NAME (First, Middle, Last): Harry Bishop		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Mason	
19a. INFORMANT'S NAME (Type/Print): Lillian J. Bishop - wife		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as 10 a-f	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fairview Mausoleum	20c. LOCATION — City or Town, State: Fairview, New Jersey	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jerianne E. Bates		22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd., Clinton, MD 20735	

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory erreet, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. Cardiac arrest Hypotension

DUE TO (OR AS A CONSEQUENCE OF):
b. Coronary Artery Disease

Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic Lung disease

DUE TO (OR AS A CONSEQUENCE OF):
d. Cardiac Arrhythmia - Ventricular Fibrillation

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Laxmi Berwa Attending	29c. LICENSE NUMBER: D-24535	29d. DATE SIGNED (Month, Day, Year) ▶ 8/16/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Laxmi N. Berwa, M.D., 7700 Old Branch Ave., Clinton, MD 20735

31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25043

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jennie M Buttiglieri			2. DATE OF DEATH (Month / Day / Year): 8 / 14 / 89	3. TIME OF DEATH: 6.40 P M
4. SOCIAL SECURITY NUMBER: 158-09-0794	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 09-24-18	8. BIRTHPLACE (State or Foreign Country): Mass.
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Clinton		9c. COUNTY OF DEATH: Prince Georges
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: P.G.	10c. CITY, TOWN OR LOCATION: Clinton		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7806 Pinewood Drive		10f. ZIP CODE: 20735		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Cologero Buttiglieri		18. MOTHER'S NAME (First, Middle, Maiden Surname): Maria Conzolo		
19a. INFORMANT'S NAME (Type/Print): Marei Stallings		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10a-10f.		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Epiphany Episocopal Cem.		20c. LOCATION — City or Town, State: Forestville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeanne L [illegible]		22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old alexander Ferry road Clinton, Maryland 20735		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ATHEROSCLEROTIC HEART DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CORONARY ARTERY DISEASE.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CACHEXIA, PSYCHOSIS.
ANEMIA
URINARY TRACT INFECTION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD FACC	29c. LICENSE NUMBER: D24477	29d. DATE SIGNED (Month, Day, Year) ▶ 8/15/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAJ. SAMTANI MD 9131 PISCATAWAY RD CLINTON MD		
31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: AUG 25 '89 Julia Davidson-Randall	

DHMH-18 Rev 1/89

89 25044

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William C. Barbee (William / BARBEE)		2. DATE OF DEATH: MONTH 08 DAY 21 YEAR 89	3. TIME OF DEATH: 900 P M
4. SOCIAL SECURITY NUMBER: 351-24-4882	6. SEX: 1 [X] M 2 [ ] F	8. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 14, 1912
8. BIRTHPLACE (State or Foreign Country): VA			
9a. FACILITY NAME (If not institution, give street and number): Greater Laurel-Beltsville Hosp.	9b. CITY, TOWN OR LOCATION OF DEATH: Laurel	9c. COUNTY OF DEATH: P.G.	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Prince Geroges	10c. CITY, TOWN OR LOCATION: Laurel	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 14200 Laurel Park Dr.	10f. ZIP CODE: 21707	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accountant	16b. KIND OF BUSINESS/INDUSTRY: U.S. Air Force
17. FATHER'S NAME (First, Middle, Last): Herbert Barbee		18. MOTHER'S NAME (First, Middle, Maiden Surname): Blanche Stover	
19a. INFORMANT'S NAME (Type/Print): Kirtley Stone Barbee		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6001 Valley View Dr. Alex., VA 22301	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Comfort Crematory	20c. LOCATION — City or Town, State: Alex., VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vernon Simmons		22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPSIS	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gregory A. Compton MD

29c. LICENSE NUMBER: D24924

29d. DATE SIGNED (Month, Day, Year) ▶ 08-21-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GREGORY A. COMPTON MD 0317 Cherry Lane Laurel MD 20707

31. DATE FILED (Month, Day, Year): AUG 25 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Tindall

10

DHMH-16 Rev 1/89

89 25045

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOYCE BROOM — Joyce L. Broom	2. DATE OF DEATH: MONTH 8 DAY 23 YEAR 89	3. TIME OF DEATH: 5:30 P M		
4. SOCIAL SECURITY NUMBER: 251-36-2014	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 26, 1912	8. BIRTHPLACE (State or Foreign Country): South Carolina
9a. FACILITY NAME (If not institution, give street and number): 4601 Old Branch Avenue	9b. CITY, TOWN OR LOCATION OF DEATH: Temple Hills	9c. COUNTY OF DEATH: Prince George's		
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Temple Hills	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 4601 Old Branch Avenue	10f. ZIP CODE: 20748	10g. CITIZEN OF WHAT COUNTRY?: United States		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home		
17. FATHER'S NAME (First, Middle, Last): Lafayette Lawton	18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Stone			
19a. INFORMANT'S NAME (Type/Print): Lynn Broome	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4601 Old Branch Avenue, Temple Hills, MD 20748			
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory	20c. LOCATION — City or Town, State: Silver Spring, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellen H. Rapp	22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. COLON CANCER.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1) EDEMA, DEPENDENT 2 CELLULITIS OF PERINEUM 3 ATRIAL FIBRILLATION 4 HYPOTHYROIDISM 5 DEHYDRATION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Michael York MD	D28494	▶ 8/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL YORK MD — 5506 GREEN LANDING RD UPPER MARLBORO MD 20772

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 28 '89	Julia Davidson-Randall

DNMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25046

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY H. BAUER			2. DATE OF DEATH: MONTH 8 DAY 22 YEAR 89	3. TIME OF DEATH: 5:45P M
4. SOCIAL SECURITY NUMBER: 218-26-7671	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 58 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 05-17-31	8. BIRTHPLACE (State or Foreign Country): D.C.
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Laurel	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 9105 Contee Road	10f. ZIP CODE: 20708	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Julius M. Buckler		18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Wesley	
19a. INFORMANT'S NAME (Type/Print): Francis C. Bauer		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9105 Contee Road Laurel, Maryland 20708	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus	20c. LOCATION — City or Town, State: Baltimore
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Natale Sulas 759		22. NAME AND ADDRESS OF FACILITY: 7601 Sandy SpringRD. FLeck Funeral Home, Inc. Laurel, Maryland 20707	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinomatosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Carcinoma of Breast c Metastasis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Cachexia/Debility	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: DO 1332	29d. DATE SIGNED (Month, Day, Year): 8/22/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT DEITZ, M.D. 5711 SARVIS AVE.#100, RIVERDALE, MD. 20737		
31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25047 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George Michael BROWN
2. DATE OF DEATH (Month, Day, Year): August 17 1989
3. TIME OF DEATH: 4:10 A M
4. SOCIAL SECURITY NUMBER: 272-05-1797A
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): March 15, 1903
8. BIRTHPLACE (State or Foreign Country): LaPlata, Md.
9a. FACILITY NAME (If not institution, give street and number): AMI Doctors' Hospital 8118 Goodluck Rd.
9b. CITY, TOWN OR LOCATION OF DEATH: Lanham, Md.
9c. COUNTY OF DEATH: Price george's Co.

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: Cheverly
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 6008 State Street
10f. ZIP CODE: 20785
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4th Grade — College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver & Clerk
16b. KIND OF BUSINESS/INDUSTRY: Grocery & Liquor Store
17. FATHER'S NAME (First, Middle, Last): Henry James Brown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Dent
19a. INFORMANT'S NAME (Type/Print): Furman E. Brown (Son)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6008 State Street Cheverly, Maryland 20785
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Cemetery
20c. LOCATION — City or Town, State: Hyattsville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randy Brohawn
22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiorespiratory Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerotic Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF): Congestive Heart Failure	
	c. ~~DUE TO (OR AS A CONSEQUENCE OF):~~ and	
	d. Bronchopneumonia + Sepsis	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. LICENSE NUMBER: D16197
29d. DATE SIGNED (Month, Day, Year): 8-17-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANDREAS C. LAMA — 9330 Lanham-Severn Rd. Lanham, MD
31. DATE FILED (Month, Day, Year): AUG 25 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 25048

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
Dorothy Elizabeth Bowers		08 / 14 / 89	11:15 a M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
579-03-5311	1 ☐ M 2 ☒ F	71 YRS.			02/26/18	Mt. Rainier, MD

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
AMI DRS' HOSPITAL OF P.G. COUNTY	Lanham	Prince George's

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Prince George's	Landover Hills	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4106 Fairfax Street	20784	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12	----------	Secretary	U.S. Govt

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Albert Merrill West	Mary Agnes Schrepler

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Wayne E. Bowers	2016 Tundra Court, Annapolis, Maryland 21401

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Ft. Lincoln Cemetery	Brentwood, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Christina L. Kopczyk	Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Metastatic End Stage Carcinomas Pancreas

DUE TO (OR AS A CONSEQUENCE OF):
b. Acute Renal Failure

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. Hyperkalemia. Pulmonary edema.

DUE TO (OR AS A CONSEQUENCE OF):
d. Cardio Respiratory Arrest

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Anemia
Liver Metastasis

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☐ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Hema P. Yadla M.D	A21883	▶ 8/14/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
HEMA P. YADLA - 9470 ANNAPOLIS Rd LANHAM M.D. 20706

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 89	Julia Davidson-Randall AUG 25

DHMH-18 Rev 1/89

Item:7 per FH G-656
10-30-89 cm

89 25049

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLARA BERSCHNEIDER		2. DATE OF DEATH (Month, Day, Year): 8 24 89	3. TIME OF DEATH: 605P M
4. SOCIAL SECURITY NUMBER: 172-03-5392	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 93 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH: ~~Oct. 4, 1896~~ Apr. 10, 1896
8. BIRTHPLACE (State or Foreign): Summerhill, Pa.			
9a. FACILITY NAME (If not institution, give street and number): Carroll Manor Nursing Home	9b. CITY, TOWN OR LOCATION OF DEATH: Hyattsville	9c. COUNTY OF DEATH: Prince George's	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Hyattsville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4922 LaSalle Road	10f. ZIP CODE: 20782	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): None	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk	16b. KIND OF BUSINESS/INDUSTRY: Retail	
17. FATHER'S NAME (First, Middle, Last): Clement Berschneider	18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Smay		
19a. INFORMANT'S NAME (Type/Print): Carl Strawbridge (Nephew)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13514 Coronado Drive Spring Hill, Florida 34609		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mary's Cemetery	20c. LOCATION — City or Town, State: Croyle Township, Pa.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mark A Bateman	22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	ACUTE MYOCARDIAL INFARCTION	10 MINS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	YEARS
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CONGESTIVE HEART FAILURE
MITRAL REGURGITATION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Marta Anne Schneider MD	29c. LICENSE NUMBER: D 26331	29d. DATE SIGNED (Month, Day, Year): ▶ 8/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARTA ANNE SCHNEIDER MD 5401 MACARTHUR BLVD N.W. WASH. D.C. 20016

31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25050 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ruth Browning				2. DATE OF DEATH (Month, Day, Year): August 10 1989	3. TIME OF DEATH: 6:45 PM M
4. SOCIAL SECURITY NUMBER: 578-38-6553	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): May 4, 1925	8. BIRTHPLACE (State or Foreign Country): South Carolina
9a. FACILITY NAME (If not institution, give street and number): Golden Oaks			9b. CITY, TOWN OR LOCATION OF DEATH: Laurel		9c. COUNTY OF DEATH: Prince Georges
RESIDENCE OF DECEDENT					
10a. STATE: D.C.	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Washington, D.C.			10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2900 14th Street, N.W. Apt. 603		10f. ZIP CODE: 20009		10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housekeeper		16b. KIND OF BUSINESS/INDUSTRY: Domestic	
17. FATHER'S NAME (First, Middle, Last): George D. Wallace			18. MOTHER'S NAME (First, Middle, Maiden Surname): J. Gertrude Wallace		
19a. INFORMANT'S NAME (Type/Print): Ruthie Browning Wynn		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4500 Holmehurst Way West Bowie, Maryland 20715			
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Webb Memorial Lawns		20c. LOCATION — City or Town, State: Shelby, North Carolina	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William R. Bruce		22. NAME AND ADDRESS OF FACILITY: McGuire Funeral Service 7400 Georgia Avenue, N.W. Washington, D.C.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Met. Colon Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 6 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D35430	▶ 8/11/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): 14333 Laurel Bowie Rd Suite 307 Laurel, MD 20708

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 89	Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25051

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT W. CARTIN — Robert Carter
2. DATE OF DEATH: Month 9 Day 2 Year 89 — Sept. 2, 1989
3. TIME OF DEATH: 7:45 a M
4. SOCIAL SECURITY NUMBER: 262-01-5117
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 23, 1905
8. BIRTHPLACE (State or Foreign Country): Georgia
9a. FACILITY NAME (If not institution, give street and number): Leland Memorial Hosp. — Leland Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale — Riverdale
9c. COUNTY OF DEATH: Prince George — Prince George

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Hyattsville
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4905 41st Place
10f. ZIP CODE: 20781
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [XX] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [XX] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [XX] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plastering Contractor
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): Thomas Cartin
16. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown
19a. INFORMANT'S NAME (Type/Print): Mrs. Robert W. Cartin
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4905 41st Place, Hyattsville, Maryland 20781
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Slate Hill Baptist Ch. Cemetery
20c. LOCATION — City or Town, State: Albemarle Cnty, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jack D Friend
22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Colon Carcinoma.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: V. P. Chandar.
29c. LICENSE NUMBER: D16380
29d. DATE SIGNED (Month, Day, Year): 9/12/89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): V. Poorn Chandar, 4404 Queensbury Road, Riverdale, Md. 20737
31. DATE FILED (Month, Day, Year): SEP 14 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Pender

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25052 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Maggie L Cobb					2. DATE OF DEATH (Month, Day, Year): August 23, 1989		3. TIME OF DEATH: 1145 A.M.
4. SOCIAL SECURITY NUMBER: 579-36-4201	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 1/4/15		8. BIRTHPLACE (State or Foreign Country): ST.GEORGE SC
9a. FACILITY NAME (If not institution, give street and number): P.G GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY MD.			9c. COUNTY OF DEATH: PRINCE GEORGE	
RESIDENCE OF DECEDENT							
10a. STATE: WASHINGTON	10b. COUNTY: N/A		10c. CITY, TOWN OR LOCATION: D.C.			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 601 L ST. S.E. APT 625			10f. ZIP CODE: 20003			10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 8+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC			16b. KIND OF BUSINESS/INDUSTRY: N/A	
17. FATHER'S NAME (First, Middle, Last): BRAMO COBBS			18. MOTHER'S NAME (First, Middle, Maiden Surname): LULA DESSASO				
19a. INFORMANT'S NAME (Type/Print): MEMPHIS JACOBS			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7816 BURNSIDE RD.PALMER PK.MD. 20785				
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LINCOLN MEMORIAL			20c. LOCATION — City or Town, State: SUITLAND MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ernest E. Williams			22. NAME AND ADDRESS OF FACILITY: VANN&WM F.H.4804 GA.AVE WASH.D.C. 20011				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Augusto P. Rodriguez MD	D21230	August 23, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25053 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harold F. Conkwright			2. DATE OF DEATH (Month, Day, Year): August 17, 1989	3. TIME OF DEATH: 8:35 P M
4. SOCIAL SECURITY NUMBER: 315-09-2169	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-24-1919	8. BIRTHPLACE (State or Foreign Country): Kentucky
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Clinton		9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Kentucky	10b. COUNTY: Breckenridge	10c. CITY, TOWN OR LOCATION: Harned	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: Star Rt. 651 Box 16A	10f. ZIP CODE: 40144	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW11	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Pipe Fitter -Retired	16b. KIND OF BUSINESS/INDUSTRY: Pipe Fitter Union 597	
17. FATHER'S NAME (First, Middle, Last): John N. Conkwright		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nora Fitzhugh	
19a. INFORMANT'S NAME (Type/Print): Joy E. Conkwright		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4108 Gulfview Dr. Newark, Delaware 19702	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Kingswood Cemetery	20c. LOCATION — City or Town, State: Kingswood, Kentucky	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ernest D. Lee		22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, 6633 Old Alexander Ferry Rd. Clinton, Md. 20735	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	Hypertensive cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD	29c. LICENSE NUMBER: D21230	29d. DATE SIGNED (Month, Day, Year): August 18, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748

31. DATE FILED (Mo. Day Yr.): AUG 25 89	32. REGISTRAR'S SIGNATURE: Gloria Faulkner-Randall

DHMH-16 Rev 1/89

10
1-VA

ITEM:19a per FH G-658
1-19-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25054
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert Tinsley Cox, Sr.				2. DATE OF DEATH (Month, Day, Year): August 25, 1989	3. TIME OF DEATH: 1 A M
4. SOCIAL SECURITY NUMBER: 214-26-1456	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 60 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): March 16, 1929	8. BIRTHPLACE (State or Foreign Country): Arkansas
9a. FACILITY NAME (If not institution, give street and number): 3053 Brinkley Road, Apt. T-1			9b. CITY, TOWN OR LOCATION OF DEATH: Temple Hills		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Temple Hills	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3053 Brinkley Rd., Apt. T-1		10f. ZIP CODE: 20748	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Korean	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Printer	16b. KIND OF BUSINESS/INDUSTRY: South Capitol Press	
17. FATHER'S NAME (First, Middle, Last): M. L. Fletcher Cox		18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Bolling	
19a. INFORMANT'S NAME: Barbara Jo ~~Elgen~~ ELGIN Cox		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3053 Brinkley Rd., Apt. T-1, Temple Hills, Md. 20748	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery	20c. LOCATION — City or Town, State: Cheltenham, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George P. Kalas		22. NAME AND ADDRESS OF FACILITY: George P. Kalas Funeral Home, 6160 Oxon Hill Rd., Oxon Hill, Md. 20745	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertensive arteriosclerotic cardiovascular disease	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD	29c. LICENSE NUMBER: D21230	29d. DATE SIGNED (Month, Day, Year): August 25, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez MD 5009 Rayburn Ct. Camp Springs Maryland 20748		
31. DATE FILED (Month, Day, Year): AUG 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(5)

89 25055

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ADDIE FRANCES CANE			2. DATE OF DEATH (Month, Day, Year): AUGUST 23 1989	3. TIME OF DEATH: 9:30 A M
4. SOCIAL SECURITY NUMBER: 405-01-2924	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-29-1915	8. BIRTHPLACE (State or Foreign Country): Kentucky
9a. FACILITY NAME (If not institution, give street and number): Malcolm Grow Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Suitland		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: Bryans Road	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 2 Box 182B		10f. ZIP CODE: 20616	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Telephone Operator	16b. KIND OF BUSINESS/INDUSTRY: Communication	
17. FATHER'S NAME (First, Middle, Last): Clarence H. Hasch		18. MOTHER'S NAME (First, Middle, Maiden Surname): Hettie Bell Dorsey	
19a. INFORMANT'S NAME (Type/Print): Donald B. Cane	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2 Box 182B, Bryans Road, Md. 20616		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery	20c. LOCATION — City or Town, State: Cheltenham, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward G. Mudd	22. NAME AND ADDRESS OF FACILITY: Huntt Funeral Home P. O. Box 156, Waldorf, Md. 20604-0156		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SADDLE PULMONARY EMBOLISM	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. STATUS POST HIP FRACTURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-14-89	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: Slipped in hallway
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): O.P. Clinic, Andrews AFB/Hosp			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Andrews AFB, Maryland

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ AUGUST, 23, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
ALAN W. CHRISTENSEN, MAJ, USAF, MC MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB, MD 20331-5300	AUG 25 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

August 30 Medical Examiner, Prince George's County, Maryland

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25056 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH A. CROCKER / ELIZABETH CROCKER			2. DATE OF DEATH (Month, Day, Year) 8 28 89	3. TIME OF DEATH 0860 AM
4. SOCIAL SECURITY NUMBER 579 28 9012	5. SEX 1 ☐ M 2 ☒ F	6. AGE (in yrs. last birthday) 64 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year) Mar. 17, 1925	8. BIRTHPLACE (State or Foreign Country) South Carolina
9a. FACILITY NAME (If not institution, give street and number) 4708 Sellman Road		9b. CITY, TOWN OR LOCATION OF DEATH Beltsville	9c. COUNTY OF DEATH Prince George	

RESIDENCE OF DECEDENT

10a. STATE MD	10b. COUNTY Prince George	10c. CITY, TOWN OR LOCATION Beltsville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER 4708 Sellman Road	10f. ZIP CODE 20705	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	

11. MARITAL STATUS 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 8 / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker	16b. KIND OF BUSINESS/INDUSTRY At Home	
17. FATHER'S NAME (First, Middle, Last) John Ashley		18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Conley	
19a. INFORMANT'S NAME (Type/Print) Murray C. Crocker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4708 Sellman Rd., Beltsville, MD, 20705	
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery	20c. LOCATION — City or Town, State Arlington, Va.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ William T. Conrad		22. NAME AND ADDRESS OF FACILITY TAKOMA FUNERAL HOME, INC. 254 Carroll St. N.W. Washington DC	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Myocardial Infarction	minutes
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Arteriosclerotic Cardiovascular Dis	years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Paul Arlewine Deputy Medical Examiner	29c. LICENSE NUMBER D01852	29d. DATE SIGNED (Month, Day, Year) ▶ 8/28/89	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) PAUL A DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781			
31. DATE FILED (Month, Day, Year) AUG 29 '89	32. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

OHMH-16 Rev 1/89

4

89 25057

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Samuel Earl [redacted] Dustin

2. DATE OF DEATH (Month, Day, Year): 8 13 89

3. TIME OF DEATH: 0200 AM

4. SOCIAL SECURITY NUMBER: 219-10-6614

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 10-9-09

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Greater Laurel Beltsville Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Laurel MD

9c. COUNTY OF DEATH: Prince George

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Silver Spring, Maryland

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 13308 Old Columbia Pike

10f. ZIP CODE: 20904

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW 2

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 7 — College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): carpenter

16b. KIND OF BUSINESS/INDUSTRY: construction

17. FATHER'S NAME (First, Middle, Last): Clinton Dustin

18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa Beall

19a. INFORMANT'S NAME (Type/Print): Joan Bailey

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16509 Magnolia Court, Silver Spring, Md 20904

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Union Cemetery

20c. LOCATION — City or Town, State: Burtonsville, Md

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Louise Donaldson

22. NAME AND ADDRESS OF FACILITY: Donaldson Funeral Home, Laurel, Md

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA AND SEPSIS

DUE TO (OR AS A CONSEQUENCE OF): b. ADULT RESPIRATORY DISTRESS SYND.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. ATRIAL FIBRILLATION

DUE TO (OR AS A CONSEQUENCE OF): d. GANGRENE - PERIPH VASC. DISEASE

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David B. Goodhart MD

29c. LICENSE NUMBER: 36822

29d. DATE SIGNED (Month, Day, Year): 8/13/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 14201 LAUREL PARK DRIVE, #214, LAUREL, MD 20707

31. DATE FILED (Month, Day, Year): AUG 18 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(12)

89 25058

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILL DAVIS			2. DATE OF DEATH (Month, Day, Year): 8-3-89	3. TIME OF DEATH: 12 47 PM
4. SOCIAL SECURITY NUMBER: 302-36-6745	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 47 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10/19/44	8. BIRTHPLACE (State or Foreign Country): ALABAMA
9a. FACILITY NAME (If not institution, give street and number): Leland Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale		9c. COUNTY OF DEATH: PG

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: PRINCE GEORGES	10c. CITY, TOWN OR LOCATION: Hyattsville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 630 Sheridan St #4		10f. ZIP CODE: 20783	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Security Guard	16b. KIND OF BUSINESS/INDUSTRY: Private	
17. FATHER'S NAME (First, Middle, Last): Will Davis SR.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Gladden Davis		
19a. INFORMANT'S NAME (Type/Print): Mary Davis	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1757 Noble Rd, E Cleveland OH 10, 44112		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lincoln Memorial Cem.	20c. LOCATION — City or Town, State: Suitland, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Johnson & Jenkins Inc. 7116 Kennedy St, N.W. Wash. DC		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIO PULMONARY ARREST

DUE TO (OR AS A CONSEQUENCE OF):
b. ACUTE PULMONARY EDEMA

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC MYELOCYTIC LEUKEMIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. Dashottar MD	29c. LICENSE NUMBER: D25977	29d. DATE SIGNED (Month, Day, Year): 8/3/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. A. Dashottar, 7207 Hanover Parkway #A Greenbelt MD 20770		
31. DATE FILED (Month, Day, Year): AUG 18 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

(10)

Items:23 thru 28f per ME G-655
9-29-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25059
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Kelvin Andrew Downs				2. DATE OF DEATH (Month, Day, Year): 8 31 89	3. TIME OF DEATH: 10:00 A. M
4. SOCIAL SECURITY NUMBER: 251 06 8737	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 32 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 3-1-57	8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not institution, give street and number): I-95 at Rt. 414			9b. CITY, TOWN OR LOCATION OF DEATH: Temple Hills		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: North Beach	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4109 3rd Street		10f. ZIP CODE: 20714	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1975-76	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic	16b. KIND OF BUSINESS/INDUSTRY: Automotive
17. FATHER'S NAME (First, Middle, Last): Rohmie Odell Downs		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ellen Mae Godfrey	
19a. INFORMANT'S NAME (Type/Print): JoAnn T. Behr		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as 10 above	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Md Veterans Cem.	20c. LOCATION — City or Town, State: Cheltenham (PG) MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. Michael Phyps RFH		22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home Owings, MD 20736	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) scene	
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-31-89	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
	28d. DESCRIBE HOW INJURY OCCURED: Passenger in Tow Truck/Tractor Trailer Collision		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): I-95 Rt. 414 Inner Lop Temple Hills, P.G. Co, Md.	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita Korell	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 9-1-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn St., Balto., Md. 21201

31. DATE FILED (Month, Day, Year): SEP 6 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randolph

DHMH-16 Rev 1/89

#23 thru 28f,FilmG656 10/21/89 kam

89 25060

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANKLIN Charles DORSEY			2. DATE OF DEATH (Month, Day, Year): 9 2 1989	3. TIME OF DEATH: 12:40A M
4. SOCIAL SECURITY NUMBER: 495 60 1873	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 34 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-16-54	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Prince George's General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: Chesapeake Beach	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4350 Christiana Parran Rd.		10f. ZIP CODE: 20732	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Surveyor	16b. KIND OF BUSINESS/INDUSTRY: Surveying	
17. FATHER'S NAME (First, Middle, Last): Franklin C. Dorsey		18. MOTHER'S NAME (First, Middle, Maiden Surname): Irma M. Hance	
19a. INFORMANT'S NAME (Type/Print): Irma M. Dorsey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4250 Christiana Parran Rd., Ches Beach, MD 20732	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Emmanuel UM Church Cem.	20c. LOCATION — City or Town, State: Huntingtown (Calvert)MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. Michael Hyde RFH		22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home Owings, MD 20736	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple Injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 9/1/89	28b. TIME OF INJURY: 11:46p M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURRED: truck, fell & was run over Subject Attempted to jump on
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): road			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Upper Marlboro,Md. 9207 Old Marlboro Pk.,

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles P. Kokes MD	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 9-2-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn St., Balto., MD 21201

31. DATE FILED (Month, Day, Year): SEP 6 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DEDOMINICIS

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25061 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. DECEDENT'S NAME (First, Middle, Last): Ann Frances DeDominicis			2. DATE OF DEATH (Month, Day, Year): 8 24 89	3. TIME OF DEATH: 3:50 A M
4. SOCIAL SECURITY NUMBER: 034-24-2204	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 24, 1934	8. BIRTHPLACE (State or Foreign Country): Holyoke Mass.
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: CLINTON		9c. COUNTY OF DEATH: Prince Georges
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Ft. Washington		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 605 Luxor Court		10f. ZIP CODE: 20744		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 8+): N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Frank A. Hurley		18. MOTHER'S NAME (First, Middle, Maiden Surname): Beatrice G. Picard		
19a. INFORMANT'S NAME (Type/Print): John A DeDominicis		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10 A-F		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cemetery		20c. LOCATION — City or Town, State: Clinton Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Walter O. Lee		22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old ALexander Ferry Rd Clinton, Md 20735		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. inanition	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. metastatic lung cancer	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David Haidak	29c. LICENSE NUMBER: D17605	29d. DATE SIGNED (Month, Day, Year): 8/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David Haidak, MD 8926 Woodyard Suite 201 Clinton Md 20735		
31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: AUG 25 '89 Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25062

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed ... by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elisha C. Essex			2. DATE OF DEATH (Month / Day / Year): 8 / 24 / 89	3. TIME OF DEATH: 4:10 AM
4. SOCIAL SECURITY NUMBER: 231-36-4222	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9/13/05	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Pineview Manor Extended Care		9b. CITY, TOWN OR LOCATION OF DEATH: Clinton, Md.		9c. COUNTY OF DEATH: P. G.

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Oxon Hill	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1313 Southern Ave., #331		10f. ZIP CODE: 20745	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES: XX	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): James Cabbell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Parrish	
19a. INFORMANT'S NAME (Type/Print): Withers Scofield Essex	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9106 Pineview Lane Clinton, MD. 20744		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. PleasantBapt.(churchcemetery)	20c. LOCATION — City or Town, State: Tyro,VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. B. Jenkins	22. NAME AND ADDRESS OF FACILITY: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD. 20785		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Severe Congestive Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Cardiomegaly, Arteriosclerosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD Attending	29c. LICENSE NUMBER: D-24535	29d. DATE SIGNED (Month, Day, Year): 8/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):

31. DATE FILED (Month, Day, Year): AUG 28 '89	32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

DHMH-15 Rev 1/89

(5)

ITEM:7 per FH G-654
8-30-89 ij

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-25063

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Forbes			2. DATE OF DEATH (Month, Day, Year): August 25, 89	3. TIME OF DEATH: 11:30 M
4. SOCIAL SECURITY NUMBER: 219-16-0868	5. SEX: 1 ☐ M 2 XX F	6. AGE (In yrs. last birthday): 64 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 8-25-89 8/24/25	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Prince Georges Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly		9c. COUNTY OF DEATH: P.G.
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Glenarden		10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO
10e. STREET AND NUMBER: 8407 Hamlin Street		10f. ZIP CODE: 20801		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): James Boone		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Washington		
19a. INFORMANT'S NAME (Type/Print): Mary William		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1213 Miller Road Landover, MD. 20785		
20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Memorial Park		20c. LOCATION — City or Town, State: Landover, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John B Jenkins		22. NAME AND ADDRESS OF FACILITY: J.B. Jenkins Funeral Home 7474 Landover Road Landover, MD. 20785		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Diabetic arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 XX NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 XX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Augusto P Rodriguez MD	D21230	August 26, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P Rodriguez MD, 5709 Raeburn Ct Capitol Hts MD 20743

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 28 '89	Julia Davidson-Rowdabe

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25064

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

3

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JESSIE GLENN			2. DATE OF DEATH (Month, Day, Year): AUGUST 18 89	3. TIME OF DEATH: 11 50PM M
4. SOCIAL SECURITY NUMBER: 579-03-6566	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-14-20	8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PRINCE GEORGE'S

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: PRINCE GEORGE'S	10c. CITY, TOWN OR LOCATION: CAPITOL HEIGHTS	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 504 62nd PLACE #C		10f. ZIP CODE: 20743	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: DOMESTIC	
17. FATHER'S NAME (First, Middle, Last): SAMUEL GIBSON		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELLA GIBSON	
19a. INFORMANT'S NAME (Type/Print): DAVID GLENN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 504 62nd Place #C CAPITOL HEIGHTS, MD. 20743	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LINCOLN CEMETERY	20c. LOCATION — City or Town, State: SUITLAND, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: B. C. Taylor		22. NAME AND ADDRESS OF FACILITY: ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASH. D.C. 20019	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CEREBRO VASCULAR ACCIDENT	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. HYPERTENSION	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Surinder RESIDENT PHYSICIAN	29c. LICENSE NUMBER: D38529	29d. DATE SIGNED (Month, Day, Year): ▶ 8/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SURINDER P.S. VOHRA 3001 HOSPITAL P.G. GENERAL HOSPITAL DRIVE CHEVERLY MD 20785

31. DATE FILED (Month, Day, Year): AUG 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

3

89 25065

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

15

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Goulette Wright		2. DATE OF DEATH (Month, Day, Year): Aug 27 1989	3. TIME OF DEATH: 1:26 P M
4. SOCIAL SECURITY NUMBER: 577-32-7647	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov 25 1927
8. BIRTHPLACE (State or Foreign Country): Vermont			
9a. FACILITY NAME (If not institution, give street and number): 9123 Kinzer St	9b. CITY, TOWN OR LOCATION OF DEATH: Lanham	9c. COUNTY OF DEATH: Prince Georges	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Lanham	10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 9123 Kinzer Street	10f. ZIP CODE: 20706	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII/Korea	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Cauc.
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Substation Operator	16b. KIND OF BUSINESS/INDUSTRY: PEPCO	
17. FATHER'S NAME (First, Middle, Last): William C. Wright	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ora Goulette		
19a. INFORMANT'S NAME (Type/Print): Dorothy R. Wright	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9123 Kinzer St. Lanham, Maryland 20706		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery	20c. LOCATION — City or Town, State: Cheltenham, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard Rendon	22. NAME AND ADDRESS OF FACILITY: Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Chronic Myocardial (2) Infarction DUE TO (OR AS A CONSEQUENCE OF):	
c.	DUE TO (OR AS A CONSEQUENCE OF):	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) / 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John S. Rogers M.D.	29c. LICENSE NUMBER: D09975	29d. DATE SIGNED (Month, Day, Year): Aug 27 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John S. Rogers M.D. 1919 Seminary Road Silver Spring, Maryland		
31. DATE FILED (Month, Day, Year): AUG 30 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

Item:23pt2 per Dr. G-656
10-6-89 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25066 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary M. Sunday Goldstein
2. DATE OF DEATH (Month, Day, Year): 8 21 89
3. TIME OF DEATH: 7 30 A M
4. SOCIAL SECURITY NUMBER: 213-42-5211
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 89 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 11/23/99
8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): Greenbelt Nursing Center
9b. CITY, TOWN OR LOCATION OF DEATH: Greenbelt, Md.
9c. COUNTY OF DEATH: P.G.

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: Hyattsville
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4834 67th Avenue
10f. ZIP CODE: 20784
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — Americen Indien, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): George Stevens
18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Thaddeus
19a. INFORMANT'S NAME (Type/Print): Kate R. Catloth (Daughter)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4834 67th Avenue Hyattsville, Maryland 20784
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bethel Cemetery
20c. LOCATION — City or Town, State: Alexandria,. Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jack D Freund
22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	6 day
DUE TO (OR AS A CONSEQUENCE OF):	b. asphyxia	6 da
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c.	
DUE TO (OR AS A CONSEQUENCE OF):	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Duke Feeding
dyspnea related to heart disease
congestive heart failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): 8 24 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Till Bergemann, M.D. 115 Center Way, Greenbelt, Maryland 20770
31. DATE FILED (Month, Day, Year): AUG 25 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25067

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN GODFREY, Jr.			2. DATE OF DEATH (Month / Day / Year): 8 / 16 / 89	3. TIME OF DEATH: 8 46 AM
4. SOCIAL SECURITY NUMBER: 220-12-2656	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 62 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 04/11/27	8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PRINCE GEORGE CNTY

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Landover Hills	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 7105 Webster Street		10f. ZIP CODE: 20784	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5+): --------	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steamfitter	16b. KIND OF BUSINESS/INDUSTRY: Railroad	
17. FATHER'S NAME (First, Middle, Last): John Godfrey, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha H. Hinkle	
19a. INFORMANT'S NAME (Type/Print): John Godfrey, III		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7105 Webster Street, Landover Hills, MD 20784	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery	20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randy Brohaun		22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):
b. pulmonary embolus -
DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic Obstructive pulmonary disease
DUE TO (OR AS A CONSEQUENCE OF):
d. Coronary artery disease

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert [illegible] MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 8/16/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4410 74th Ave Landover Hills MD 20784

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE: AUG 25 '89 Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(15) (IVA)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25068 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(4)

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ada Christine Hook				2. DATE OF DEATH (Month, Day, Year): 8 22 89	3. TIME OF DEATH: 5:17 M
4. SOCIAL SECURITY NUMBER: 577-40-8057 F-2	6. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10 24 00	8. BIRTHPLACE (State or Foreign Country): Maryland
8a. FACILITY NAME (If not institution, give street and number): Pineview Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Clinton		9c. COUNTY OF DEATH: Prince George's	
RESIDENCE OF DECEDENT					
10a. STATE: Washington DC	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Washington, D.C.		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 4018 13th St. N.E.		10f. ZIP CODE: 20017		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Thomas Tydings		16. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Rebecca Butler			
19a. INFORMANT'S NAME (Type/Print): Christine Fox		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10 a-f			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Thomas Episcopal Ch. Cem		20c. LOCATION — City or Town, State: Croom, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Geraanne L Bates		22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd Clinton, Md20735			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASHD - Cerebral Arteriosclerosis - CVA

TIA - Pacemaker placement

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)

HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 5 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
R Moseman MD	12564	8/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): REZA MOSTAFA 9235 25th Ave Md-20747

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 89	AUG 25 '89 Julia Davidson-Randall

DHMH-15 Rev 1/89

89 25069

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): IONIA HOWE				2. DATE OF DEATH (Month, Day, Year): Aug 31 89	3. TIME OF DEATH: 4:30 PM
4. SOCIAL SECURITY NUMBER: —	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 31, 1900	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Presidential Wood Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Adelphi		9c. COUNTY OF DEATH: Prince George

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: Huntingtown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2125 Stinnett Road		10f. ZIP CODE: 20639	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 8+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Sewell Howe		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah J. Russell	
19a. INFORMANT'S NAME (Type/Print): Estep A. Kyler		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2125 Stinnett Road Huntingtown, Md 20639	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Hope Church Cemetery	20c. LOCATION — City or Town, State: Sunderland, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Spencer K. Sewell		22. NAME AND ADDRESS OF FACILITY: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, Md	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CONGESTIVE HEART FAILURE — DAYS

DUE TO (OR AS A CONSEQUENCE OF):
b. ACUTE MYOCARDIAL INFARCTION — DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ATHEROSCLEROTIC CEREBROVASCULAR DISEASE

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D22700	29d. DATE SIGNED (Month, Day, Year): ▶ 9/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PETER M SCHUSCER 7500 Greenway Ctr Dr. Greenbelt Md 20770		
31. DATE FILED (Month, Day, Year): SEP 5 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMH-16 Rev 1/89

3

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25070 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Doris ANN Hobson
2. DATE OF DEATH (Month, Day, Year): Aug 24 89
3. TIME OF DEATH: 2:40 PM
4. SOCIAL SECURITY NUMBER: 577-28-7117
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 66 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Oct. 7, 1922
8. BIRTHPLACE (State or Foreign Country): Wash. D.C.
9a. FACILITY NAME (If not institution, give street and number): Leland Mem. Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale
9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George
10c. CITY, TOWN OR LOCATION: College Park
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3521 Marlborough Way
10f. ZIP CODE: 20740
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): highschool — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Bertram Taylor Anderson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Annabelle Marshall
19a. INFORMANT'S NAME (Type/Print): Cecil Hobson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3521 Marlborough Way College Park, Md 20740
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): George Washington Cemetery
20c. LOCATION — City or Town, State: Adelphi, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Hines-Rinaldi F.H. 11800 New Hampshire Silver Spring, Md

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Dis.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic Myocardial Dis. Yrs	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D09975
29d. DATE SIGNED (Month, Day, Year): Aug. 24 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): Dr. John Rogers 1919 Seminary Rd Silver Spring, Md.
31. DATE FILED (Month, Day, Year): AUG 25'89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

4

UNKNOWN 89-146

89 25071

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dored A. Hamrick			2. DATE OF DEATH (Month, Day, Year): 8-21-89	3. TIME OF DEATH: 9:45AM M
4. SOCIAL SECURITY NUMBER: 218-32-7822	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 54 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2-9-35
8. BIRTHPLACE (State or Foreign Country): West Virginia				
9a. FACILITY NAME (If not institution, give street and number): Woods off B Street at dead end		9b. CITY, TOWN OR LOCATION OF DEATH: Laurel		9c. COUNTY OF DEATH: Prince Georges Co.

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Laurel	10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO
10e. STREET AND NUMBER: 12 C Street Apt. 1		10f. ZIP CODE: 20707	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+): unknown	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Collector	16b. KIND OF BUSINESS/INDUSTRY: Trach Company	
17. FATHER'S NAME (First, Middle, Last): XXXXXXXXXXXXX John Q. Hamrick		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosetta M. Knight	
19a. INFORMANT'S NAME (Type/Print): Mary Reynolds		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 414 Gilbert Street Trainer, PA 19103	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Washington Crematory	20c. LOCATION — City or Town, State: Laurel, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Natalie Thea Ray		22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, MD 20707	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic ethanol abuse

24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence XXX 6 ☐ Other (Specify) Woods	
27. MANNER OF DEATH: XX 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 8-22-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan, M.D. 111 Penn Street, Baltimore, MD 21201		
31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 25072

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Florence Amelia Hoal
2. DATE OF DEATH (Month, Day, Year): Aug 15 89
3. TIME OF DEATH: 4:30p M
4. SOCIAL SECURITY NUMBER: 579-30-9751
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 05/17/16
8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): 8312 14th Avenue
9b. CITY, TOWN OR LOCATION OF DEATH: Hyattsville
9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: Hyattsville
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 8312 14th Avenue
10f. ZIP CODE: 20783
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th — College (1-4 or 5+): ---
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Richard E. Sedgewick
18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Mortimer
19a. INFORMANT'S NAME (Type/Print): Eugene R. Day
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1419 S.E. 37th Avenue, Ocala, Florida 32671
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery
20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randy Brohawn
22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Myocardial Inf.	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Chronic Myocardial Disease	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John L. Ryan M.D.
29c. LICENSE NUMBER: D29975
29d. DATE SIGNED (Month, Day, Year): Aug. 15, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print)
31. DATE FILED: AUG 25 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25073

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(4)

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Maria Haberer			2. DATE OF DEATH (Month, Day, Year): Aug 21 1989	3. TIME OF DEATH: 7:17 AM
4. SOCIAL SECURITY NUMBER: 579-34-6605	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 04-04-1901	8. BIRTHPLACE (State or Foreign Country): Germany
9a. FACILITY NAME (If not institution, give street and number): Leland Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale	9c. COUNTY OF DEATH: Prince George	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: College Park	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 8705 Rhode Island Avenue		10f. ZIP CODE: 20740	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade; College (1-4 or 5+): ----------		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Karl E. Stoll		18. MOTHER'S NAME (First, Middle, Maiden Surname): Maria Junginger		
19a. INFORMANT'S NAME (Type/Print): Erwin C. Haberer, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8705 Rhode Island Avenue, College Park, Md. 20740		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery	20c. LOCATION — City or Town, State: Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jack D Friend		22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, HYattsville, Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or reapiretory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. Congestive Cardiac failure
DUE TO (OR AS A CONSEQUENCE OF):
c. Atherosclerotic Cardiac Disease
DUE TO (OR AS A CONSEQUENCE OF):
d. Hypertensive heart Disease

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.
Dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To tha best of my knowledge, death occurred at the time, data and place, and dua to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: G.M. DIA, M.D

29c. LICENSE NUMBER: D22549

29d. DATE SIGNED (Month, Day, Year): ▶ 8/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 6510 Kenilworth Ave Riverdale M.D. 20737

31. DATE FILED (Month, Day, Year): AUG 25 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25074

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT S. HAGER			2. DATE OF DEATH (Month, Day, Year): 08/22/89	3. TIME OF DEATH: 5.40P M
4. SOCIAL SECURITY NUMBER: 578-48-8105	5. SEX: 1 [X] M 2 [ ] F	6. AGE (in yrs. last birthday): 53 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 13,1936	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: P.G.	10c. CITY, TOWN OR LOCATION: College Park	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4711 Berwynhouse RD.		10f. ZIP CODE: 20740	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): ------	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tow Truck Driver	16b. KIND OF BUSINESS/INDUSTRY: Arthur Brother Co.	
17. FATHER'S NAME (First, Middle, Last): Maurice M. Hager		18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna I. Sullivan	
19a. INFORMANT'S NAME (Type/Print): Edna Sendish		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 233 Pinewood Dr, Waldorf, MD. 20601	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cemetery	20c. LOCATION — City or Town, State: Annapolis, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas S. Chambers # 670		22. NAME AND ADDRESS OF FACILITY: W.W.Chambers Co. Inc. 5801 Cleveland Ave. Riverdale, MD. 20737	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Central nervous system failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):
c. Cancer - metastatic lung
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Martin Queller
29c. LICENSE NUMBER: D23743
29d. DATE SIGNED (Month, Day, Year): ▶ 8/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARTIN WEITZ 7525 Odenway, CR Drive Greenbelt MD 20770

31. DATE FILED (Month, Day, Year): AUG 25 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMN-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25075 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MABLE LAHOMA JOHNSTON
2. DATE OF DEATH: MONTH AUGUST DAY 20 YEAR 1989
3. TIME OF DEATH: 11:10 P M
4. SOCIAL SECURITY NUMBER: 490-24-9258
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Nov/17/1914
8. BIRTHPLACE (State or Foreign Country): Missouri
9a. FACILITY NAME (If not institution, give street and number): 1107 Palmer Road #B-6
9b. CITY, TOWN OR LOCATION OF DEATH: Oxon Hill
9c. COUNTY OF DEATH: Prince George

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Prince George
10c. CITY, TOWN OR LOCATION: Oxon Hill
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1107 Palmer Road #B-6
10f. ZIP CODE: 20745
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 6+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): operator
16b. KIND OF BUSINESS/INDUSTRY: telephone company
17. FATHER'S NAME (First, Middle, Last): W. Whitson Lair
18. MOTHER'S NAME (First, Middle, Maiden Surname): Maude Lair
19a. INFORMANT'S NAME (Type/Print): Betty Croasdale
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2408 Kingsway Road Ft Washinton MD 20744
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery
20c. LOCATION — City or Town, State: Arlington VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Melanie Wilhelm
22. NAME AND ADDRESS OF FACILITY: Robert E Wilhelm Funeral Home, Inc. Suitland MD 20746

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez M.D.
29c. LICENSE NUMBER: D21230
29d. DATE SIGNED (Month, Day, Year): August 21, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748
31. DATE FILED (Month, Day, Year): AUG 29 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

DHMH-16 Rev 1/89

89 25076

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sarah M. St. John		2. DATE OF DEATH (Month, Day, Year): August 16 1989	3. TIME OF DEATH: 8:55 AM
4. SOCIAL SECURITY NUMBER: 230-20-8918	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11-03-24
8. BIRTHPLACE (State or Foreign Country): Virginia			
9a. FACILITY NAME (If not institution, give street and number): 1805 Plymouth Court	9b. CITY, TOWN OR LOCATION OF DEATH: Bowie	9c. COUNTY OF DEATH: Prince Georges	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Bowie	10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 1805 Plymouth Court	10f. ZIP CODE: 20715	10g. CITIZEN OF WHAT COUNTRY? United States	

11. MARITAL STATUS: 1 ☐ Never Married ☒ 2 Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Person	16b. KIND OF BUSINESS/INDUSTRY: Candy Store	
17. FATHER'S NAME (First, Middle, Last): Charles Crawford	18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Pearl Pennington		
19a. INFORMANT'S NAME (Type/Print): Robert V. St. John	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 above		
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Grandview Memory Gardens	20c. LOCATION — City or Town, State: Tazewell, VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E Evans Pres.	22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. malignant lymphoma	4y
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: coronary insufficiency

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D04483	29d. DATE SIGNED (Month, Day, Year): ▶ 8.17.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 115 Centerway Rd. Greenbelt M.D 20770 Dr. Till Bergemann		
31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

Items:23 thru 28f per ME G-657
11-17-89 cm UNKNOWN 89-149

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25077 REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
Jeffrey	Dean	Jarvis	8-23-89	3:43AM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
212 - 82 - 2839	1 [X] M 2 [ ] F	29 YRS.			Feb 24, 1960	Virginia

9a. FACILITY NAME (If not Institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
CRX railroad tracks N. of Cherry Ln Bridge	Laurel	Prince Georges Co.

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Prince George	Laurel	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
804 8th Street	20707	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	1 [ ] YES 2 [X] NO Specify:	Specify White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 8 +)		
Grade 10		Carpenter	Construction

17. FATNER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Warren Winston Parker	Catherine Clark

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Deborah Knisley	11281 Harding Road Laurel, Maryland 20707

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Meadowridge Memorial Park	Dorsey, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Donaldson Funeral Home P.A.	Donaldson Funeral Home P.A. 313 Talbott Ave Laurel, Maryland 20707

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. ~~Struck by train~~	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
XX YES 2 [ ] NO	XX [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 XX YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 XX Other (Specify) Scene

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined	8-23-89	M	1 [ ] YES 2 [X] NO	Subject struck by train

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
on railroad tracks	CRX railroad tracks N. of Cherry Lane Bridge Laurel, Md

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Charles P. Kokes MD	OCME	▶ 8-23-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles P. Kokes,M.D. 111 Penn Street,Baltimore,MD 21201 vc

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 89	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 25078

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thelma Erleen JANUSZ			2. DATE OF DEATH (Month, Day, Year): August 23, 1989	3. TIME OF DEATH: 4:32P M
4. SOCIAL SECURITY NUMBER: 240-40-2353	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 57 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 2, 1932
8. BIRTHPLACE (State or Foreign Country): Rockingham, North Carolina				
9a. FACILITY NAME (If not institution, give street and number): Doctor's Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Lanham	9c. COUNTY OF DEATH: Prince George's		
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Greenbelt	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 7513 Mandan Road	10f. ZIP CODE: 20770	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. OECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): 2 Years	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waitress	16b. KIND OF BUSINESS/INDUSTRY: Italian Inn		
17. FATHER'S NAME (First, Middle, Last): John T. Brown	18. MOTHER'S NAME (First, Middle, Maiden Surname): Thelma E. McClure			
19a. INFORMANT'S NAME (Type/Print): Christine J. Smith (Daughter)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 49 3rd Avenue Rockingham, North Carolina 28379			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Eastside Cemetery	20c. LOCATION — City or Town, State: Rockingham, North Carolina		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jack D Friend	22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Adult Respiratory Distress Syndrome	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Septic Shock	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Renal Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. multi organ failure	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Intestinal obstruction with gangrene & perforation

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 8-23-89	28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D34722	29d. DATE SIGNED (Month, Day, Year): August 24, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Vicken Pogossian, M.D. 5632 Annapolis Rd. Bladensburg, Md. 20710		
31. DATE FILED: AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25079

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LEROY JACKSON				2. DATE OF DEATH (Month, Day, Year): 8 25 89	3. TIME OF DEATH: 10:40 PM
4. SOCIAL SECURITY NUMBER	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): May 30, 1917	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Golden Oaks Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Laurel		9c. COUNTY OF DEATH: Pr. George	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Laurel	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1011 Turney Ave		10f. ZIP CODE: 20707	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver	16b. KIND OF BUSINESS/INDUSTRY: Dept Of Agriculture	
17. FATHER'S NAME (First, Middle, Last): Irvin Jackson	18. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Mitchell		
19a. INFORMANT'S NAME (Type/Print): Mrs Grace A. Jackson	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1011 Turney Ave, Laurel, Md #20707		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Md National Park	20c. LOCATION — City or Town, State: Laurel, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George R. Snowden	22. NAME AND ADDRESS OF FACILITY: Snowden Funeral Home #20850 246 N. Washington St. Rockville, Md		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. RECURRENT PNEUMONIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DYSPHAGIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. ORGANIC BRAIN SYNDROME	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. CHRONIC ALCOHOLISM	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [EM] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D24035	29d. DATE SIGNED (Month, Day, Year) ▶ 8/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E S MACHADO 321 PRINCE GEORGE ST LAUREL MD 20707

31. DATE FILED (Month, Day, Year): AUG 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25080
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Leon Stanley Klosky
2. DATE OF DEATH (Month, Day, Year): Aug 18 1989
3. TIME OF DEATH: 11:18 M
4. SOCIAL SECURITY NUMBER: 162-14-4477
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 77 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): February 16, 1912
8. BIRTHPLACE (State or Foreign Country): Canonsburg, Pennsylvania

9a. FACILITY NAME (If not institution, give street and number): 8506 49th Avenue
9b. CITY, TOWN OR LOCATION OF DEATH: College Park
9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: College Park
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 8506 49th Avenue
10f. ZIP CODE: 20740
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor
16b. KIND OF BUSINESS/INDUSTRY: U.S. Government

17. FATHER'S NAME (First, Middle, Last): Stanislaus Kolaczynski
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Remias

19a. INFORMANT'S NAME (Type/Print): Anita Garner (Daughter)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5010 Laguna Road College Park, Maryland 20740

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): George Washington Cemetery
20c. LOCATION — City or Town, State: Adelphi, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randy Brohauer
22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Myocardial Dis.	7
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Chronic Myocardial Dis.	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. LICENSE NUMBER: D09975
29d. DATE SIGNED (Month, Day, Year): Aug. 19, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): Aug. 25, 89
32. REGISTRAR'S SIGNATURE: AUG 25 '89 Julia Davidson-Randall

OHMH-16 Rev 1/89

(8) IVA

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25081 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RONALD JOSEPH KENNEDY			2. DATE OF DEATH (Month, Day, Year): AUGUST 23 1989	3. TIME OF DEATH: 9:45 PM
4. SOCIAL SECURITY NUMBER: 025-22-2804	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 58 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 9, 1931	8. BIRTHPLACE (State or Foreign Country): Mass.
9a. FACILITY NAME (If not institution, give street and number): Malcolm Grow Hospital AAFB		9b. CITY, TOWN OR LOCATION OF DEATH: Camp Springs		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Clinton	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 8404 Deborah Street		10f. ZIP CODE: 20735	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electronics Technician	16b. KIND OF BUSINESS/INDUSTRY: Ret USAF Government

17. FATHER'S NAME (First, Middle, Last): John A. Kennedy	18. MOTHER'S NAME (First, Middle, Maiden Surname): Beatrice Ann Pints
19a. INFORMANT'S NAME (Type/Print): Joan Kennedy	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10 A-F

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mary's Church Cem.	20c. LOCATION — City or Town, State: Laurence Mass.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd Clinton, Md 20735	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. RESPIRATORY ARREST
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DISSEMINATED SQUAMOUS CELL CARCINOMA
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	26e. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.	29c. LICENSE NUMBER: ---	29d. DATE SIGNED (Month, Day, Year): ▶ AUGUST 23, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JEFFERSON HARMAN, CAPT, USAF, MC	MALCOLM GROW USAF MEDICAL CENTER ANDREWS A F B, MD 20331-5300	
31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: AUG 25 '89 Julia Davidson-Randall	

DHMH-16 Rev 1/89

10 -VA

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25082 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Jeum	Box	Kim	Aug 21 1989	10:45 PM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
218-94-4193	1 ☐ M 2 ☒ F	82 YRS.			Aug 28 1906	Korea

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Leland Memorial Hospital	Riverdale	Pr. Georges

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Prince Georges	New Carrollton	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
7609 Topton Street	20784	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: Korean

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 8+)		
Unk.		Homemaker	

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Soon Ki Choi	In Soon Oh

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Young Soo Kim	7609 Topton Street New Carrollton, MD 20784

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Cedar Hill Crematory	Suitland, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Richard Hale	Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Stroke with left hemiplegia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Senile dementia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Dehydration	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[illegible] MD	D 14905	▶ 8/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Yeal-Kwon H. Yoon, MD. 7307 Baltimore Ave. College Park Md. 20740

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 '89	Julia Davidson-Randall AUG 25 89

DHMH-18 Rev 1/89

89 25083

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Otis Loman		2. DATE OF DEATH (Month, Day, Year): August 20, 1989	3. TIME OF DEATH: 6:30 a.m. M
4. SOCIAL SECURITY NUMBER: 405-14-1705	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 02/22/22
			8. BIRTHPLACE (State or Foreign Country): Kentucky
9a. FACILITY NAME (If not institution, give street and number): 6918 Shepherd Street	9b. CITY, TOWN OR LOCATION OF DEATH: Landover Hills	9c. COUNTY OF DEATH: Prince George's	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Landover Hills	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 6918 Shepherd Street		10f. ZIP CODE: 20784	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Wife
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): ----------	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dry Wall Contractor	16b. KIND OF BUSINESS/INDUSTRY: Self Employed	
17. FATHER'S NAME (First, Middle, Last): William Loman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Eva J. Carpenter	
19a. INFORMANT'S NAME (Type/Print): Pearl Loman (Wife)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6918 Shepherd Street Landover Hills, Maryland 20784		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FT. LINCOLN CEMETERY	20c. LOCATION — City or Town, State: BRENTWOOD, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jack D Friend	22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Bronchogenic Carcinoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic Obstructive Pulmonary Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF OEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) end manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, dete end place, and due to the ceuse(e) end manner ee stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Louis Steinberg	29c. LICENSE NUMBER: D12015	29d. DATE SIGNED (Month, Day, Year): ▶ 8-21-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Louis Steinberg 6492 Landover Road, Landover, Maryland 20785		
31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

(3) (1 of 1)

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25084 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLYDE BERTRAM MERRITT					2. DATE OF DEATH (Month, Day, Year): Aug 23 89	3. TIME OF DEATH: 8 03 M
4. SOCIAL SECURITY NUMBER: 225-10-3689	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): May 27, 1907	8. BIRTHPLACE (State or Foreign Country): South Carolina
9a. FACILITY NAME (If not institution, give street and number): Leland Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale		9c. COUNTY OF DEATH: Prince George's	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Prince George's		10c. CITY, TOWN OR LOCATION: College Park		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 8806 48th Avenue			10f. ZIP CODE: 20740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade; College (1-4 or 5+): ----------			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Crane Operator		16b. KIND OF BUSINESS/INDUSTRY: Construction	
17. FATNER'S NAME (First, Middle, Last): Cephas Merritt			18. MOTNER'S NAME (First, Middle, Maiden Surname): unavailable			
19a. INFORMANT'S NAME (Type/Print): Mary F. Merritt			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8806 48th Avenue, College Park, Md. 20740			
20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery		20c. LOCATION — City or Town, State: Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jack D Friend			22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Balto. Avenue, Hyattsville, Md. 20781			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ea cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
[X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined			1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John A. Rogers 2nd M.D.	D09975	▶ Aug. 23 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25085

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY L. MC CARTHY
2. DATE OF DEATH (Month, Day, Year): 8 . 14 . 89
3. TIME OF DEATH: 3 PM. M
4. SOCIAL SECURITY NUMBER: 216-22-0234
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1/16/16
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: CLINTON
9c. COUNTY OF DEATH: PRINCE GEORGE'S

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: Seat Pleasant
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6010 George Palmer Highway
10f. ZIP CODE: 20743-1772
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cleaning
16b. KIND OF BUSINESS/INDUSTRY: Private
17. FATHER'S NAME (First, Middle, Last): George Emanuel Thomas
16. MOTHER'S NAME (First, Middle, Maiden Surname): Lena M. Henson
19a. INFORMANT'S NAME (Type/Print): Kenneth McCarthy
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6010 George Palmer Highway Seat Pleasant, MD. 20743
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Memorial Park
20c. LOCATION — City or Town, State: Landover, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Tommy C. Neal Sr.
22. NAME AND ADDRESS OF FACILITY: J.B Jenkins Funeral Home 7474 Landover Road Landover, MD. 20785

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attend[illegible] permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMATOSIS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST

b. COLON CANCER.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S. JOSEF MD.
29c. LICENSE NUMBER: D 26011
29d. DATE SIGNED (Month, Day, Year): ▶ 8/14/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4467 Old Branch Avenue/Temple Hill, Md

31. DATE FILED (Month, Day, Year): AUG 18 89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25086

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elizabeth Irene ~~XXXXXXX~~ McCabe
2. DATE OF DEATH — MONTH: August DAY: 27, YEAR: 1989
3. TIME OF DEATH: 12 30 P M
4. SOCIAL SECURITY NUMBER: 091-22-6134
5. SEX: 1 ☐ M 2 ☒ ~~X~~ F
6. AGE (In yrs. last birthday): 61 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): March 31, 1928
8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): 6405 McCahill Drive
9b. CITY, TOWN OR LOCATION OF DEATH: Laurel
9c. COUNTY OF DEATH: Prince George

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George
10c. CITY, TOWN OR LOCATION: Laurel
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ ~~X~~ NO
10e. STREET AND NUMBER: 6405 McCahill Drive
10f. ZIP CODE: 20707
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ ~~X~~ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ ~~X~~ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ ~~X~~ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Harold Kennedy
18. MOTHER'S NAME (First, Middle, Maiden Surname): Bridget Kennedy
19a. INFORMANT'S NAME (Type/Print): John F. McCabe
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6405 McCahill Drive Laurel, MD 20707
20a. METHOD OF DISPOSITION: 1 ☒ ~~X~~ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ivy Hill Cemetery
20c. LOCATION — City or Town, State: Laurel, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, MD 20707

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD
29c. LICENSE NUMBER: D21230
29d. DATE SIGNED (Month, Day, Year): ▶ August 27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez; Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748
31. DATE FILED (Month, Day, Year): AUG 29 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25087

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT MELTZ		2. DATE OF DEATH (Month, Day, Year): AUGUST 19, 1989	3. TIME OF DEATH: 10:39A M
4. SOCIAL SECURITY NUMBER: 197-18-7078	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 08-12-21
8. BIRTHPLACE (State or Foreign Country): PA.			
9a. FACILITY NAME (If not institution, give street and number): Malcolm Grow USAF Med. Cen.	9b. CITY, TOWN OR LOCATION OF DEATH: Camp Springs	9c. COUNTY OF DEATH: P.G.	
RESIDENCE OF DECEDENT			
10a. STATE: Md.	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: Waldorf	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1609 Debra Drive	10f. ZIP CODE: 20601	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Special Police	16b. KIND OF BUSINESS/INDUSTRY: D.C. Gov't	
17. FATHER'S NAME (First, Middle, Last): John J. Meltz	18. MOTHER'S NAME (First, Middle, Maiden Surname): Gertrude Muller		
19a. INFORMANT'S NAME (Type/Print): Margaret E. Meltz	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10a-10f.		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cem.	20c. LOCATION — City or Town, State: Arlington, Va.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mont D. Lee	22. NAME AND ADDRESS OF FACILITY: Lee Funeral home, Inc. 6633 Old Alexander Ferry Road Clinton, Maryland 20735		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIOGENIC SHOCK	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PROBABLE MASSIVE PULMONARY EMBOLUS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Chas A. Weber MD		AUGUST 19, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHARLES A. WEBER, MAJ, USAF, MC — MALCOLM GROW USAF MEDICAL CENTER ANDREWS A F B MD 20331-5300

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 89	Linda Watson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25088 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary B. Moore
2. DATE OF DEATH (Month, Day, Year): 08 - 20 - 89
3. TIME OF DEATH: 11:00 A.M.
4. SOCIAL SECURITY NUMBER: 169-22-2843
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 59 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-15-29
8. BIRTHPLACE (State or Foreign Country): Penn.

9a. FACILITY NAME (If not institution, give street and number): 14400 Town Farm Rd.
9b. CITY, TOWN OR LOCATION OF DEATH: Upper Marlboro
9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: Upper Marlboro
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 14400 Town Farm Road
10f. ZIP CODE: 20772
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XXX YES 2 ☐ NO IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Ex. Sec. Imigation/Nat.
16b. KIND OF BUSINESS/INDUSTRY: U.S. Govt. Justice Dept.

17. FATHER'S NAME (First, Middle, Last): Michael Blaskovich
18. MOTHER'S NAME (First, Middle, Maiden Surname): Teresa Hrebicek

19a. INFORMANT'S NAME (Type/Print): Valeria Drag
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10 A/F

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Comfort Cemetery
20c. LOCATION — City or Town, State: Alexandria Virginia

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeranne L Bates
22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd Clinton, Md 20735

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Amyotrophic Lateral Sclerosis
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dysphagia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Gary W. Jones, MD
29c. LICENSE NUMBER: D30111
29d. DATE SIGNED (Month, Day, Year): ▶ 08-21-1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gary W. Jones, M.D. P.O. Box 385 Laurel Md. 20707

31. DATE FILED (Month, Day, Year): AUG 25 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall AUG 25 '89

IF THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
IF THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

15
1-VA

DHMH-16 Rev 1/89

ITEMS:23 thru 28f per ME G-659
1-5-90 cm Unknown 89-153

89 25089

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last): WILLA MAE MANGUM MOORE

2. DATE OF DEATH (Month, Day, Year): 8-28-89

3. TIME OF DEATH: 6:30PM M

4. SOCIAL SECURITY NUMBER: 171-20-2935

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 74 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 9 26 14

8. BIRTHPLACE (State or Foreign Country): South Carolina

9a. FACILITY NAME (If not institution, give street and number): Senior Citizen Wooded area

9b. CITY, TOWN OR LOCATION OF DEATH: Park Robert Watkins Regional

9c. COUNTY OF DEATH: Prince Georges Co.

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Prince George

10c. CITY, TOWN OR LOCATION: Largo

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER: 12109 Chesterton Drive

10f. ZIP CODE: 20772

10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nursing Assistant

16b. KIND OF BUSINESS/INDUSTRY: Psychiatric Hospital

17. FATHER'S NAME (First, Middle, Last): John Sanders

18. MOTHER'S NAME (First, Middle, Maiden Surname): Blanche Miller

19a. INFORMANT'S NAME (Type/Print): Barbara Harmon

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12109 Chesterton Drive Upper Marlboro, MD 20772

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gulph Christian Cemetery

20c. LOCATION — City or Town, State: Conshohocken, PA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lillian L. DeBaptiste

22. NAME AND ADDRESS OF FACILITY: DeBaptiste Funeral Homes, Inc.
Worthington and Miner Sts. West Chester, PA 19382

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. NO ANATOMIC CAUSE OF DEATH

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXYES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XXYES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence XX Other (Specify): Scene

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 8-28-89

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO

28d. DESCRIBE HOW INJURY OCCURED: UNKNOWN

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): WOODED AREA

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): ROBERT WATKINS REGIONAL PARK P.G. CO., MD.

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. M.D.

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): ▶ 8-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type or Print): Mario F. Golle,Jr.,M.D. 111 Penn Street, Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year): SEP 14 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25090 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lanty M. O'Dell
2. DATE OF DEATH (Month, Day, Year): Aug. 24, 1989
3. TIME OF DEATH: 7:30 A M
4. SOCIAL SECURITY NUMBER: 579-18-1142
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Apr. 17, 1914
8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Paint Branch Home
9b. CITY, TOWN OR LOCATION OF DEATH: Adelphi
9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince Georges
10c. CITY, TOWN OR LOCATION: College Park
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 10107 52nd. Avenue
10f. ZIP CODE: 20740
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1-12 — College (1-4 or 5+): --
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bus Driver
16b. KIND OF BUSINESS/INDUSTRY: D.C. Transit
17. FATHER'S NAME (First, Middle, Last): Everett O'Dell
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mae Harlow
19a. INFORMANT'S NAME (Type/Print): Marjorie Perdue-White
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10107 52nd. Avenue, College Park, Md. 20740
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
20c. LOCATION — City or Town, State: Brentwood, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 New Hampshire Ave., S.S. Md. 20904

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiorespiratory arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Ischemic cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d. ~~Chronic obstructive pulmonary disease~~ no

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive pulmonary dis
24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Mark D Goldman MD
29c. LICENSE NUMBER: D22123
29d. DATE SIGNED (Month, Day, Year): 8/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr.Mark Goldman 6525 Belcrest Road Hyattsville,Md.
31. DATE FILED (Month, Day, Year): AUG 25'89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

10

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25091

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

5

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dorothy Mae Pringle

2. DATE OF DEATH (Month, Day, Year): 8-22-89

3. TIME OF DEATH: 9:30PM M

4. SOCIAL SECURITY NUMBER: 246-44-7172

5. SEX: 1 ☐ M 2 XX F

6. AGE (In yrs. last birthday): 59 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 8-21-30

8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA

9a. FACILITY NAME (If not institution, give street and number): 6968 Walker Mill Road

9b. CITY, TOWN OR LOCATION OF DEATH: Capitol Heights

9c. COUNTY OF DEATH: Prince Georges Co.

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: PRINCE GEORGE'S

10c. CITY, TOWN OR LOCATION: CAPITOL HEIGHTS

10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO

10e. STREET AND NUMBER: 6968 WALKER MILL ROAD #A1

10f. ZIP CODE: 20743

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 X NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): SECONDARY
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER

16b. KIND OF BUSINESS/INDUSTRY: FEDERAL GOVERNMENT

17. FATHER'S NAME (First, Middle, Last): UNKNOWN

18. MOTHER'S NAME (First, Middle, Maiden Surname): ARUELLA GREEN

19a. INFORMANT'S NAME (Type/Print): JAMES PRINGLE

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7117 MARBURY COURT DISTRICT HGHTS., MD. 20747

20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LINCOLN CEMETERY

20c. LOCATION — City or Town, State: SUITLAND, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: D. L. Doyle

22. NAME AND ADDRESS OF FACILITY: ROLLINS FUNERAL HOME, INC.
4339 HUNT PLACE, N.E. WASH. D.C. 20019

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Multiple stab wounds
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? XXX 1 YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX 1 YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX 1 YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home XX Residence XXX Other (Specify) Scene

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide XXX 4 Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): ESt.8-22-89

28b. TIME OF INJURY: unkn. M

28c. INJURY AT WORK? 1 ☐ YES XXX NO

28d. DESCRIBE HOW INJURY OCCURED: Subject stabbed

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 6968 Walker Mill Rd.,Capitol Heights, Prince Georges Co.,MD

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Chas P. Kokes MD

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year) ▶ 8-23-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes,M.D. 111 Penn Street,Baltimore,MD 21201 vc

31. DATE FILED (Month, Day, Year): AUG 29 89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25092

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

2

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Clara Kate PATRICK		2. DATE OF DEATH (Month, Day, Year): August 27, 1989	3. TIME OF DEATH: 1:45P M
4. SOCIAL SECURITY NUMBER: 228-66-2571	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 22, 1900
8. BIRTHPLACE (State or Foreign Country): Tennessee			
9a. FACILITY NAME (If not institution, give street and number): A.M.I. Doctor's Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Lanham	9c. COUNTY OF DEATH: Prince George's	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Bowie	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 12809 Buckingham Drive	10f. ZIP CODE: 20715	10g. CITIZEN OF WHAT COUNTRY?: United States	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8	College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): James Searcey		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nancy Harrison	
19a. INFORMANT'S NAME (Type/Print): James C. Patrick (Son)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12809 Buckingham Drive Bowie, Maryland 20715	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Temple Hill Memorial Park	20c. LOCATION — City or Town, State: Castlewood, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wm E Bowman Jr		22. NAME AND ADDRESS OF FACILITY: Rendon/Hale Lanham Funeral Home 9013 Annapolis Road Lanham, Maryland 20706	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	cardiac arrhythmia	0
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	congestive heart failure	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	pneumonitis	
DUE TO (OR AS A CONSEQUENCE OF):		
d.	hypertension	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

(1) Alzheimer's disease with progressive dementia (3) cerebrovascular insufficiency (2) Anemia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David A. Boetcher, M.D.	29c. LICENSE NUMBER: D16063 - Md.	29d. DATE SIGNED (Month, Day, Year): ▶ 8-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David A. Boetcher 14300 Gallant Fox Lane Bowie, Maryland 20715		
31. DATE FILED (Month, Day, Year): AUG 30 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25093 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marina Perisch			2. DATE OF DEATH (Month, Day, Year): Aug. 14, 1989	3. TIME OF DEATH: 10:15 a M
4. SOCIAL SECURITY NUMBER: 334-42-5185	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov.14, 1898	8. BIRTHPLACE (State or Foreign Country): Yugoslavia
9a. FACILITY NAME (If not institution, give street and number): 4507 Keppler Pl.,		9b. CITY, TOWN OR LOCATION OF DEATH: Temple Hills		9c. COUNTY OF DEATH: Prince George's
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Temple Hills		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4507 Keppler Pl.		10f. ZIP CODE: 20748		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tailor -dress maker		16b. KIND OF BUSINESS/INDUSTRY: sewing
17. FATHER'S NAME (First, Middle, Last): Sredova Ickich		18. MOTHER'S NAME (First, Middle, Maiden Surname): Kosana Belushova		
19a. INFORMANT'S NAME (Type/Print): Bernice Plant-daughter		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as 10 a-f		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Sava Monestary		20c. LOCATION — City or Town, State: Libertyville, Ill.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeanne L Lee		22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd. Clinton, MD 20735		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LIPO CARCINOMA OF ABDOMEN

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael York MD	29c. LICENSE NUMBER: D28494	29d. DATE SIGNED (Month, Day, Year): Aug. 14, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael F. York, M.D., 5506 Green Landing Rd., Upper Marlboro, MD 20772

31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25094

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): LEROY V PENNELL
2. DATE OF DEATH — MONTH: 8 DAY: 14 YEAR: 89
3. TIME OF DEATN: 2:30 P M
4. SOCIAL SECURITY NUMBER: 577-44-6311
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-24-02
8. BIRTHPLACE (State or Foreign Country): Maine
9a. FACILITY NAME (If not institution, give street and number): So. MARYLAND HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATN: CLINTON
9c. COUNTY OF DEATN: PRINCE GEORGES Co

RESIDENCE OF DECEDENT

10a. STATE: N/A
10b. COUNTY: N/A
10c. CITY, TOWN OR LOCATION: Washington, D.C.
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3621 Newark St.,N.W.
10f. ZIP CODE: 20016
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): General Accounting Office
16b. KIND OF BUSINESS/INDUSTRY: U.S. Govt.
17. FATNER'S NAME (First, Middle, Last): Albert R. Pennell
18. MOTHER'S NAME (First, Middle, Maiden Surname): Jennie Lang
19a. INFORMANT'S NAME (Type/Print): Edwin Naugle
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4906 70th Place,Hyattsville,MD. 20784
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): N/A
20c. LOCATION — City or Town, State: N/A
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeuanne L Bates
22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home,Inc. 6633 Old Alexander Ferry Road Clinton, Maryland 20735

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio pulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF): c. Ischemic cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF): d. S/P pennant pacemaker insertion

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cachexia, anemia, pneumonia, sepsis, pancreatitis

24a. WAS AN AUTOPSY PERFORMED?
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF OEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATN: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D 20824
29d. DATE SIGNED (Month, Day, Year): ▶ 8/15/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print): 9450 Pene Ave. #18 Upper Marlboro, MD 20772
31. DATE FILED (Month, Day, Year): AUG 25 '89
32. REGISTRAR'S SIGNATURE: AUG 25 '89 Julia Davidson-Randall

DNMN-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25095

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FREDDIE LEE PARKER				2. DATE OF DEATH (Month, Day, Year): August 20 1989	3. TIME OF DEATH: 9:00pm M
4. SOCIAL SECURITY NUMBER: 228-12-7845	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): March 18, 1922	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): 3110 Amador Drive			9b. CITY, TOWN OR LOCATION OF DEATH: Landover		9c. COUNTY OF DEATH: Prince Georges
RESIDENCE OF DECEDENT					
10a. STATE: Md	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Landover			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3110 Amador Drive		10f. ZIP CODE: 20785		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): +4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accountant		16b. KIND OF BUSINESS/INDUSTRY: Government	
17. FATHER'S NAME (First, Middle, Last): Milton Parker		18. MOTHER'S NAME (First, Middle, Maiden Surname): Janie Toliver			
19a. INFORMANT'S NAME (Type/Print): Agnes Parker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3110 Amador Drive, Landover, Md 20785			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery		20c. LOCATION — City or Town, State: Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jimmy C Neal Sr.		22. NAME AND ADDRESS OF FACILITY: J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Md 20785			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Augusto P. Rodriguez MD	D-212-30	August 22-1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez MD, 5009 Rayburn Ct. Upper Marlboro, Md

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 28 89	Julia Davidson-Randall

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25096 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Richard A Peed		2. DATE OF DEATH (Month, Day, Year): 8-20-89	3. TIME OF DEATH: 1000 A M
4. SOCIAL SECURITY NUMBER: 579-22-0135	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 82 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 11/3/06
8. BIRTHPLACE (State or Foreign Country): Virginia			
9a. FACILITY NAME (If not institution, give street and number): Greater Laurel Beltsville Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Laurel	9c. COUNTY OF DEATH: Prince George	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Laurel	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7310 contee Road	10f. ZIP CODE: 20707	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1927-1928	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 8+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Welder	16b. KIND OF BUSINESS/INDUSTRY: US Bureau of Mines	
17. FATHER'S NAME (First, Middle, Last): Harry Lee Peed	18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Gutridge		
19a. INFORMANT'S NAME (Type/Print): Virginia Peed	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7310 Contee Road Laurel, Maryland 20707		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park	20c. LOCATION — City or Town, State: Jessup, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home Inc. 7601 Sandy Spring Road, Laurel MD.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the moda of dying, such ss cardiac or reapiratory srrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Daath
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Aspiration Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Posterior Mediastenal Mass	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William A Warren MD	29c. LICENSE NUMBER: MD 13916	29d. DATE SIGNED (Month, Day, Year): ▶ 8/20/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WA Warren MD 321 Prince Georges St Laurel MD 20707		
31. DATE (Month, Day, Year): AUG 25 89	32. REGISTRAR'S SIGNATURE: Julian Davidson Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25097

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH (Month - Day - Year)	3. TIME OF DEATH
ELMER W. PICKERING	08 - 12 - 89	12:30A

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
135-14-3297	1 ☒ M 2 ☐ F	68 YRS.			12-28-20	New Jersey

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Washington Adventist	Takoma Park	Prince Georges

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Anne Arundel	Bowie	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
15409 North Oak Court	20716	United States

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☒ YES 2 ☐ NO — 1942 - 1946	1 ☐ YES 2 ☒ NO Specify:	Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
10		Inspector	Aircraft Manufacturing

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Walter Pickering	Anne White

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary F. Pickering	Same as #10 above

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Mt. Oak Methodist Cemetery	Mitchellville, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Robert E. Evans, Pres	Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20716

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypercalcemia	3 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Prostatic Cancer with Osseous metastases	1 year
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	NA	M	1 ☐ YES 2 ☐ NO	

28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Kai-Yin Young, M.D.	D14730	▶ 8-12-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Kai-Yin YOUNG, M.D. 8926 Woodyard Road, #201 Clinton, MD 20735

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 '89	Richard Davidson Rendell

DHMH-16 Rev 1/89

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

12
1-VA

89 25098

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): IRENE B. RAMLER			2. DATE OF DEATH (Month, Day, Year): AUG 20 89	3. TIME OF DEATH: 1 00 P. M
4. SOCIAL SECURITY NUMBER: 578-62-8276	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 96 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): NOV. 25, 1892	8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): 7600 GLENSIDE DRIVE		9b. CITY, TOWN OR LOCATION OF DEATH: TAKOMA PARK		9c. COUNTY OF DEATH: PRINCE GEORGES
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: PRINCE GEORGES	10c. CITY, TOWN OR LOCATION: TAKOMA PARK		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 7600 GLENSIDE DRIVE		10f. ZIP CODE: 20912		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): CHARLES E. BAHLING		18. MOTHER'S NAME (First, Middle, Maiden Surname): ANIE BEITZ		
19a. INFORMANT'S NAME (Type/Print): EDWARD O. RAMLER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 513 WOODSIDE AVENUE, WILMINGTON, DELAWARE 19809		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN		20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael J Begley		22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Stroke (cerebral thrombosis) DUE TO (OR AS A CONSEQUENCE OF):	9 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CERERRAL ARTERIOSCEROSIS DUE TO (OR AS A CONSEQUENCE OF):	YEARS
	c. ARTERIOSCLEROSIS, GENERAL DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension and Arteriosclerotic Heart Disease
Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John F. Brennan Jr., M.D.	29c. LICENSE NUMBER: D04606 (Md.)	29d. DATE SIGNED (Month, Day, Year): Aug 20, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN F. BRENNAN JR. M.D. 3415 Hamilton St. Hyattsville, Md. 20782		
31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randell	

DNMN-16 Rev 1/89

10

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25099

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~Sweet~~ MAYNARD A. Sweet
2. DATE OF DEATH: Month 8 Day 23 Year 89
3. TIME OF DEATH: 7:40 A M
4. SOCIAL SECURITY NUMBER: 009-03-2913
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 71 YRS. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
7. DATE OF BIRTH (Month, Day, Year): Nov 12, 1917
8. BIRTHPLACE (State or Foreign Country): Vermont
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Clinton
9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George
10c. CITY, TOWN OR LOCATION: Forestville
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3401 Forestville Place
10f. ZIP CODE: 20747
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic
16b. KIND OF BUSINESS/INDUSTRY: Automotive
17. FATHER'S NAME (First, Middle, Last): John Sweet
18. MOTHER'S NAME (First, Middle, Maiden Surname): Evelyn Bodfish
19a. INFORMANT'S NAME (Type/Print): Maxine M. Sweet
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3401 Forestville Pl., Forestville, MD, 20747
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery
20c. LOCATION — City or Town, State: Suitland, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bryan T. Melbach
22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm, Inc. 4308 Suitland Rd. Suitland, MD.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. inanition

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. carcinoma of the larynx

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: W. Haudet
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 8/23/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):
31. DATE FILED (Month, Day, Year): AUG 29 89
32. REGISTRAR'S SIGNATURE:

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25100

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John ~~Frederick~~ Scheibach		2. DATE OF DEATH (Month, Day, Year): Aug 21 1989	3. TIME OF DEATH: 120 a M
4. SOCIAL SECURITY NUMBER: 579-30-5724	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 61 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 21, 1989
8. BIRTHPLACE (State or Foreign Country): Illinois			
9a. FACILITY NAME (If not institution, give street and number): Leland Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale, Md.	9c. COUNTY OF DEATH: Prince George's
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Hyattsville	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5305 Hamilton Street, #1		10f. ZIP CODE: 20781	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 th Grade; College (1-4 or 5+): ----------		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Building Supervisor	16b. KIND OF BUSINESS/INDUSTRY: P.G. County Board of ED.
17. FATHER'S NAME (First, Middle, Last): John L. Scheibach		18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Jobson	
19a. INFORMANT'S NAME (Type/Print): Michael D. Scheibach		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 825 Pleasant Hill Lane, Bowie, Md. 20716	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery	20c. LOCATION — City or Town, State: Cheltenham, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jack D Friend		22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Md.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hepatorenal failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Bilateral Pneumonia; Metabolic encephalopathy

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: R Bhojraj MD	29c. LICENSE NUMBER: D23181	29d. DATE SIGNED (Month, Day, Year) ▶ 8-21-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R.G. BHOJRAJ, MD. 704 Gorman Ave, T-1, Laurel, MD 20707		
31. DATE FILED: AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

(5) IVA

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25101

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES E. SCOTT, Jr.				2. DATE OF DEATH (Month, Day, Year): 08 22 89	3. TIME OF DEATH: 11 30AM M
4. SOCIAL SECURITY NUMBER: 174-18-1611	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12-8-19	8. BIRTHPLACE (State or Foreign Country): PA.
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PRINCE GEORGE'S	
RESIDENCE OF DECEDENT					
10a. STATE: MARYLAND	10b. COUNTY: P.G.	10c. CITY, TOWN OR LOCATION: Upper Marlboro		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO	
10e. STREET AND NUMBER: 17205 Usher Place		10f. ZIP CODE: 20772		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XX YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tech. Engineer GSA		16b. KIND OF BUSINESS/INDUSTRY: Federal Gov't	
17. FATHER'S NAME (First, Middle, Last): Charles E. Scott, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara Whitsel			
19a. INFORMANT'S NAME (Type/Print): Josephine Scott		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17205 Usher Pl., Upper Marlboro, MD 20772			
20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cem.		20c. LOCATION — City or Town, State: Clinton, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mark D. Rosala		22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Md. 20735			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary Arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Acute Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):
c. Coronary Artery Disease

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Depression

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 8 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: G. M. DIN, M.D.

29c. LICENSE NUMBER: D22549

29d. DATE SIGNED (Month, Day, Year) ▶ 8/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): G. M. DIN, M.D. 6510 Kenilworth Ave, Riverdale M.D. 20737

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

AUG 25 89

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25102

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Donald Edward STANGEL			2. DATE OF DEATH (Month, Day, Year): August 20, 1989	3. TIME OF DEATH: 8:55P M
4. SOCIAL SECURITY NUMBER: 123-16-7019	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 09-18-28	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Doctors Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Lanham		9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Bowie	10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO
10e. STREET AND NUMBER: 12110 Maddox Lane		10f. ZIP CODE: 20715	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FBI - Agent	16b. KIND OF BUSINESS/INDUSTRY: U.S. Government
17. FATHER'S NAME (First, Middle, Last): Charles F. Stangel		18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Rampe	
19a. INFORMANT'S NAME (Type/Print): Olive Margaret Stangel		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 above	
20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cemetery	20c. LOCATION — City or Town, State: Clinton, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Evans, Pres.		22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	gram negative sepsis	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	multiple myeloma	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Martin D. Weltz	29c. LICENSE NUMBER: D23743	29d. DATE SIGNED (Month, Day, Year) ▶ 8-21-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARTIN D. WELTZ 7525 Greenway Ct Dave Greenberg MD		
31. DATE FILED (Month, Day, Year): AUG 25 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

- 1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25103 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen Elizabeth Spencer		2. DATE OF DEATH (Month, Day, Year): 08 23 89	3. TIME OF DEATH: 320 pm M
4. SOCIAL SECURITY NUMBER: 220-12-3628	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 08-01-09
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Pineview Manor Extended Care Centre	9b. CITY, TOWN OR LOCATION OF DEATH: Clinton	9c. COUNTY OF DEATH: Prince Georges	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Brandywine	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 12211 North Keys Road	10f. ZIP CODE: 20613	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): 2 years	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk	15b. KIND OF BUSINESS/INDUSTRY: Federal Government	
17. FATHER'S NAME (First, Middle, Last): Daniel Henson	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ellen Victoria Butler		
19a. INFORMANT'S NAME (Type/Print): Gloria Perry	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12211 North Keys Rd., Brandywine, MD. 20613		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Simons Church Cemetery	20c. LOCATION — City or Town, State: Croom, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Martell Adams	22. NAME AND ADDRESS OF FACILITY: Adams Funeral Home, P.A. Aquasco Road, Aquasco, Maryland		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CORONARY ARTERY DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: RB Sawhney MD	29c. LICENSE NUMBER: D27744	29d. DATE SIGNED (Month, Day, Year) ▶ 8/23/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAJ. SAWHNEY MD 9131 PISCATAWAY RD CLINTON MD		
31. DATE FILED (Month, Day, Year): AUG 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25104
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES TUTTLE			2. DATE OF DEATH (Month, Day, Year): 8 13 89	3. TIME OF DEATH: 1 am M
4. SOCIAL SECURITY NUMBER: 705 07 7569	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 12, 1917	8. BIRTHPLACE (State or Foreign Country): 72
9a. FACILITY NAME (If not institution, give street and number): 16200 Dorset Road		9b. CITY, TOWN OR LOCATION OF DEATH: Laurel		9c. COUNTY OF DEATH: Prince Georhge
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Laurel		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 16200 Dorset Road		10f. ZIP CODE: 20707		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Property & Supplies Officer	16b. KIND OF BUSINESS/INDUSTRY: Howard County Police		
17. FATHER'S NAME (First, Middle, Last): Amos S. Tuttle		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anastasia Mc Intyre		
19a. INFORMANT'S NAME (Type/Print): Margaret Lepore	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 310 Second Street, Laurel, Md			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mary's Cemetery	20c. LOCATION — City or Town, State: Laurel, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ DeWitt Jay Donaldson	22. NAME AND ADDRESS OF FACILITY: Donaldson Funeral Home P.A. 313 Talbott Ave Laurel, Maryland 20707			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximete interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a. METASTATIC ADENOCARCINOMA COLON

DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly liet conditions, if any, leading to immediete ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initiated eventa resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying ceuee given in Part I.: METASTATIC DISEASE TO BRAIN, LUNGS HIP FRACTURE

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

26a. DATE OF INJURY (Month, Day, Year)

26b. TIME OF INJURY M

26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

26d. DESCRIBE HOW INJURY OCCURED

28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD

29c. LICENSE NUMBER: D24035

29d. DATE SIGNED (Month, Day, Year): ▶ 8/13/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 27 (Type, Print): ESMACHADO 321 PRINCE GEORGE ST LAUREL MD

31. DATE FILED (Month, Day, Year): AUG 18 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

(5)

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25105
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LOVELLA D. THOMAS		2. DATE OF DEATH (Month, Day, Year): August 29, 1989	3. TIME OF DEATH: 8:45 am M
4. SOCIAL SECURITY NUMBER: ~~223~~ 38 3100	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 57 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb. 5, 1932 — 8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Greater Laurel-Beltsville Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Laurel	9c. COUNTY OF DEATH: Prince George

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Jessup	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 8640 Mission Road	10f. ZIP CODE: 20794	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 10 — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Elmo Mace	18. MOTHER'S NAME (First, Middle, Maiden Surname): Madeline Smith		
19a. INFORMANT'S NAME (Type/Print): H. Donald Thomas	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8640 Mission Road, Jessup, Md 20794		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Emmanuel Cemetery	20c. LOCATION — City or Town, State: Scaggsville, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Louise Donaldson	22. NAME AND ADDRESS OF FACILITY: Donaldson Funeral Home, Laurel, Md		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Colon Carcinoma with generalized	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. metastasis	
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MKarim	29c. LICENSE NUMBER: D-18895	29d. DATE SIGNED (Month, Day, Year): ▶ 8-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MOBARAK KARIM 7610 CARROLL AVE, TAKOMA PARK, MD

31. DATE FILED (Month, Day, Year): AUG 30 '89	32. REGISTRAR'S SIGNATURE: Lolin Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25106 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
VIOLET	R.	TULLOCH	AUG. 21, 1989	2:25 P. M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
577-32-1656	1 ☐ M 2 ☒ F XX	82 YRS.			July 31, 1905	Wash., D.C.

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Southeran Maryland Hospital	Clinton	Prince Georges

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Prince Georges	Suitland	1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4309 Oxford Drive	20746	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed X 4 ☐ Divorced	1 ☐ YES 2 ☒ NO XX	1 ☐ YES 2 ☒ NO XX Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Housewife	Own Home

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Eugene Rosafy	Elizabeth (Unknown)

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Paul W. Foutz	4309 Oxford Dr., Suitland, MD. 20746

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	Cedar Hill Cemetery	Suitland, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Bryan F. Melbach	Robert E. Wilhelm, Inc. 4308 Suitland Rd. Suitland, MD.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

20

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Recent Cerebrovascular Accident
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Intra Cerebral Hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Prostate - U.T.I - Pneumonia

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[illegible]		▶ 8/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
REGA MOSTRAN 4225 28th AVE MD 20748

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 29 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 25107

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Orval Carl TURNER				2. DATE OF DEATH (Month, Day, Year): August 16, 1989	3. TIME OF DEATH: 6:30P M
4. SOCIAL SECURITY NUMBER: 513-16-7632	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): May 3, 1922	8. BIRTHPLACE (State or Foreign Country): Loring, Kansas
9a. FACILITY NAME (If not institution, give street and number): Doctor's Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Lanham		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Landover Hills	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: P.O. Box 2603		10f. ZIP CODE: 20784	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): 2 Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Personel Placement Specialist	16b. KIND OF BUSINESS/INDUSTRY: U.S. Government
17. FATHER'S NAME (First, Middle, Last): CArl Turner		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ora E. Green	
19a. INFORMANT'S NAME (Type/Print): Catherine L. Turner (Wife)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 2603 Landover Hills, Maryland 20784	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery	20c. LOCATION — City or Town, State: Silver Spring, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Catherine L. Turner		22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Adult Respiratory Distress Syndrome	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Louis Sternberg MD	29c. LICENSE NUMBER: D12015	29d. DATE SIGNED (Month, Day, Year): 8-16-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Louis Sternberg MD 6492 Landover Rd, Landover Md

31. DATE: AUG 25 '89	32. Julian Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25108
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for issuance of burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LEO R. WERTS			2. DATE OF DEATH (Month, Day, Year): AUG. 13, 1989	3. TIME OF DEATH: 2:55 P M
4. SOCIAL SECURITY NUMBER: 071-34-5229	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): FEB. 7, 1905	8. BIRTHPLACE (State or Foreign Country): OHIO
9a. FACILITY NAME (If not institution, give street and number): COLLINGTON EPISCOPAL LIFE CARE		9b. CITY, TOWN OR LOCATION OF DEATH: MITCHELLVILLE		9c. COUNTY OF DEATH: P.G. CO.

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: PRINCE GEORGES	10c. CITY, TOWN OR LOCATION: MITCHELLVILLE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 10450 LOTTSFORD RD.	10f. ZIP CODE: 20716	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SECRETARY	16b. KIND OF BUSINESS/INDUSTRY: FED. GOV'T.
17. FATHER'S NAME (First, Middle, Last): UNKNOWN		18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN	
19a. INFORMANT'S NAME (Type/Print): BARBARA BLATT		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 166 BARLOCK AVE., LOS ANGELES, CAL. 90049	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHAMBERS CREMATORY	20c. LOCATION — City or Town, State: RIVERDALE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. W. Chambers M00091		22. NAME AND ADDRESS OF FACILITY: W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	PNEUMONIA	DAYS
DUE TO (OR AS A CONSEQUENCE OF): b.	ASPIRATION	DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	CEREBROVASCULAR ACCIDENT	MONTHS
d.	CEREBRO- ATHEROSCLEROTIC VASCULAR DISEASE	YEARS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D22780	29d. DATE SIGNED (Month, Day, Year): 8/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Peter M. Schissler, M.D. 7500 Greenway Center Drive Greenbelt, Maryland		
31. DATE FILED (Month, Day, Year): AUG 17 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25109 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Beatrice Pauline WILDMAN			2. DATE OF DEATH (Month, Day, Year): August 18, 1989	3. TIME OF DEATH: 8:06P M
4. SOCIAL SECURITY NUMBER: 577-18-0172	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 14, 1918	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Doctors Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Lanham		9c. COUNTY OF DEATH: Prince Georges
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Bowie		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 8609 Maple Avenue		10f. ZIP CODE: 20715		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 3	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Clement H. Tydings		18. MOTHER'S NAME (First, Middle, Maiden Surname): Gertrude Florence Butler		
19a. INFORMANT'S NAME (Type/Print): William W. Wildman, Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as above		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Trinity Episcopal Cemetery		20c. LOCATION — City or Town, State: Bowie, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Evans, ESQ		22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Chronic Obstructive Pulmonary	Yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. disease	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[illegible]	D28920	▶ 8/19/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SURINDER SINGH, 9700 Berwyn House Rd. Suite 101 College Park MD. 20740.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 '89	Julia Davidson-Randall

(15)

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25110 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NELLIE Mae WISOOKER			2. DATE OF DEATH (Month, Day, Year): 08 21 89	3. TIME OF DEATH: 6 50PM M
4. SOCIAL SECURITY NUMBER: 577-34-9318	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10 08 10	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PRINCE GEORGES
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Bladensburg		10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 5999 Emerson Street		10f. ZIP CODE: 20710		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanical Assembler		16b. KIND OF BUSINESS/INDUSTRY: Manufacturing
17. FATHER'S NAME (First, Middle, Last): Not Available		18. MOTHER'S NAME (First, Middle, Maiden Surname): Not available		
19a. INFORMANT'S NAME (Type/Print): Louis Wisooker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1616 E. Bancroft Ln. Crofton, MD 21114		
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery		20c. LOCATION — City or Town, State: Arlington, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Evans, Pres		22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory Failure	20 days
DUE TO (OR AS A CONSEQUENCE OF):	Chronic obstructive lung disease	30 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- Pneumonia
- Congestive heart failure
-

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
R. Dakhee M.D.	D26492	▶ 8/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Riad Dakhee, M.D. 14300 Gallant Fox Ln. Bowie 20715

31. DATE: AUG 25 89 Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25111

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EMMA A. ALLEN					2. DATE OF DEATH (Month, Day, Year): August 20, 1989	3. TIME OF DEATH: 6:45 A M
4. SOCIAL SECURITY NUMBER: 212 56 2044	5. SEX: 1 ☐ M 2 ☒ F	5. AGE (in yrs. last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Mar. 18, 1909	8. BIRTHPLACE (State or Foreign Country): Kent Co. Md.
9a. FACILITY NAME (If not institution, give street and number): Meridian (Corscia Hills) Nursing Center			9b. CITY, TOWN OR LOCATION OF DEATH: Centreville, Md.		9c. COUNTY OF DEATH: Queen Anne	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Kent		10c. CITY, TOWN OR LOCATION: Chestertown		10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: Cannon St.			10f. ZIP CODE: 21620		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced — Widowed	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES: no		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: no		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): George W. Stowman			18. MOTHER'S NAME (First, Middle, Maiden Surname): Sadie M. Beck			
19a. INFORMANT'S NAME (Type/Print): The deceased while living			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): % Albert O. Allen Centreville, Md. 21617			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) — Burial			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Chester Cemetery 8/22/89)		20c. LOCATION — City or Town, State: Chestertown, Md. 21620	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. Willis Wells			22. NAME AND ADDRESS OF FACILITY: J. Willis Wells		P.O. Box # 264 Chestertown, Md.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Arteriosclerotic Heart Disease.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Arteriosclerosis
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
① Dm. ② Peripheral arterial Disease
③ Parkinson's Disease ④ CHF

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[illegible] MD	D21313	8/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 216 High St, Chestertown, Md. 21620 — Chestertown Md. 21620

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 22 '89	Julia Davidson-Randell

DHMH-16 Rev 1/89

89 2511

89 25112

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sarah Louisa Jones			2. DATE OF DEATH (Month, Day, Year): August 26, 1989	3. TIME OF DEATH: 11:00 AM
4. SOCIAL SECURITY NUMBER: 220-34-3704	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 08/04/16	8. BIRTHPLACE (State or Foreign Country): Ft. Myers, FL
9a. FACILITY NAME (If not institution, give street and number): At her home		9b. CITY, TOWN OR LOCATION OF DEATH: Crumpton	9c. COUNTY OF DEATH: Queen Anne's	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Queen Anne's	10c. CITY, TOWN OR LOCATIDN: Crumpton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: P. O. Box 29 (Rt. 290)		10f. ZIP CODE: 21628	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR OATES	13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EOUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 1		16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND DF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): George B. Gatling		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Stanford	
19a. INFORMANT'S NAME (Type/Print): Pierson C. Jones, Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 29 Crumpton, MD 21628	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Wesley Chapel Cemetery	20c. LOCATION — City or Town, State: Rock Hall, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thomas K. Helfenbein		22. NAME AND ADDRESS OF FACILITY: Tom Helfenbein Funeral Homes, P.A. Rt. 1 Box 66B, Chester, MD 21619	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CEREBROVASCULAR ACCIDENT	IMMEDIATE
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	DIABETES MELLITUS	yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.	ASCVD	yrs
DUE TO (OR AS A CONSEQUENCE OF):		
d.	HYPOTHYROIDISM	yrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATIDN (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: K. O'Keefe MD	29c. LICENSE NUMBER: D35259	29d. DATE SIGNED (Month, Day, Year): ▶ 8/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Kevin J. O'Keefe Dutchman's Lane, Easton, MD 21601		
31. DATE FILED (Month, Day, Year): AUG 31 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randell	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25113

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Richard Pearson
2. DATE OF DEATH (Month, Day, Year): August 23 1989
3. TIME OF DEATH: 5:50 P.M.
4. SOCIAL SECURITY NUMBER: 215-26-5381
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 22, 1918
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): R.D.#1 Bolton Woods Road
9b. CITY, TOWN OR LOCATION OF DEATH: Sudlersville
9c. COUNTY OF DEATH: Q.A.

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Q.A.
10c. CITY, TOWN OR LOCATION: Sudlersville
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: R.D. #1 Bolton Woods Road
10f. ZIP CODE: 21668
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance
16b. KIND OF BUSINESS/INDUSTRY: Farming
17. FATHER'S NAME (First, Middle, Last): Joseph Pearson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary F. Embert
19a. INFORMANT'S NAME (Type/Print): Louise Pearson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R.D. #1 Bolton Woods Road, Sudlersville, MD 21668
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sudlersville Cemetery
20c. LOCATION — City or Town, State: Sudlersville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gary B. Fellows
22. NAME AND ADDRESS OF FACILITY: Fellows Funeral Home, Box 270, Millington, MD 21651

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Metastatic Melanoma to lung	1yr.
DUE TO (OR AS A CONSEQUENCE OF):	Kidney Liver	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ASCVD & Chronic Atrial Fibrillation

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D20890
29d. DATE SIGNED (Month, Day, Year): 8/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Unicorn Medical-Millington, Md. 21651
31. DATE FILED (Month, Day, Year): AUG 28 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

8

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25114

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
AGNES E. MC GEE			August 11, 1989	4:15 P M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
219-05-9343A	1 ☐ M 2 ☒ F	78 YRS.			July 2, 1911	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
R. F. D. 1, Box 44	Pocomoke	Somerset

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Somerset	Pocomoke	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
R. F. D. 1, Box 44	21851	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
10	--	Farming	Poultry

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Edward R. Mc Gee	Edith A. Peacock

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elsie L. Mc Gee	R.F.D. 1, Box 44, Pocomoke, Md. 21851

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Salem Methodist Cemetery	Pocomoke, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Scott S. Melson	Watson & Melson Funeral Home P. O. Box 64, Pocomoke, Md. 21851

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Carcinoma Uterus with — Month
DUE TO (OR AS A CONSEQUENCE OF):
b. Generalized Peritoneal metastasis
DUE TO (OR AS A CONSEQUENCE OF):
c. Pulmonary edema — Day
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Darryl R. Barlean MD.	12765	▶ 8/17/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 25 '89	Julia Davidson-Randall

4

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 25115

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUTH H. BURNS		2. DATE OF DEATH (Month, Day, Year): AUG. 7, 1989	3. TIME OF DEATH: 9:30 P.M.
4. SOCIAL SECURITY NUMBER: 501-03-9700	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 90 YRS. (If under 1 year: Months/Days; If under 24 hrs.: Hours/Min.)	7. DATE OF BIRTH (Month, Day, Year): SEPT. 24, 1898
8. BIRTHPLACE (State or Foreign Country): N. DAKOTA			
9a. FACILITY NAME (If not institution, give street and number): BAYSIDE NURSING CENTER	9b. CITY, TOWN OR LOCATION OF DEATH: LEXINGTON PARK	9c. COUNTY OF DEATH: ST. MARY'S CO.	

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: ST. MARY'S CO.	10c. CITY, TOWN OR LOCATION: MECHANICSVILLE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: RT. 1, BOX 451A	10f. ZIP CODE: 20659	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: HOME	
17. FATHER'S NAME (First, Middle, Last): WILLIAM E. PERKINS	18. MOTHER'S NAME (First, Middle, Maiden Surname): JEAN MCCOY CARROLL		
19a. INFORMANT'S NAME (Type/Print): KATHRYN B. BRADLEN (GRANDDAUGHTER	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): BARETT MN. 56311		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LEE CREMATORY	20c. LOCATION — City or Town, State: CLINTON, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael K. Gardiner	22. NAME AND ADDRESS OF FACILITY: MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebrovascular accident	Days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D-14281	29d. DATE SIGNED (Month, Day, Year): 8/8/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WILLIAM D. BOYD, II, M.D. LEONARDTOWN, MD. 20650		
31. DATE FILED (Month, Day, Year): AUG 18 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25116 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): CALLIOPE KAPODISTRIA CHRISTODOLOU			2. DATE OF DEATH (Month, Day, Year): AUGUST 14, 1989	3. TIME OF OEATH: 4:30 p. M
4. SOCIAL SECURITY NUMBER: 066-12-7203	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JUNE 8, 1921	8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): 143 WILLIAMS DRIVE		9b. CITY, TOWN OR LOCATION OF DEATH: LEXINGTON PARK		9c. COUNTY OF DEATH: ST. MARY'S

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ST. MARY'S	10c. CITY, TOWN OR LOCATION: LEXINGTON PARK	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 143 WILLIAMS DRIVE		10f. ZIP CODE: 20653	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLERK TYPIST	16b. KIND OF BUSINESS/INDUSTRY: CIVIL SERVICE	
17. FATHER'S NAME (First, Middle, Last): PETER KAPODISTRIA		18. MOTHER'S NAME (First, Middle, Maiden Surname): AGLIA LAMBROS	
19a. INFORMANT'S NAME (Type/Print): NICHOLAS CHRISTODOLOU		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 143 WILLIAMS DRIVE, LEXINGTON PARK, MD. 20653	
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CYPRESS HILLS	20c. LOCATION — City or Town, State: BROOKLYN, NEW YORK
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward N. Brinsfield		22. NAME AND ADDRESS OF FACILITY: BRINSFIELD FUNERAL HOME P.O. BOX 279, LEONARDTOWN, MD. 20650	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiopulmonary Failure	hrs
DUE TO (OR AS A CONSEQUENCE OF): b.	Amyotrophic Lateral Sclerosis	2yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's D.E.?

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF OEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. P. Jarboe M.D.	29c. LICENSE NUMBER: D06419	29d. DATE SIGNED (Month, Day, Year): ▶ 8-15-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. PATRICK JARBOE, M.D., MEDICAL ARTS BLDG., LEONARDTOWN, MARYLAND 20650		
31. DATE FILED (Month, Day, Year): AUG 16 89	32. REGISTRAR'S SIGNATURE: Jeka Davidson-Randall	

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 25117 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES ALFORD CLINTON			2. DATE OF DEATH (Month, Day, Year): August 16, 1989	3. TIME OF DEATH: 4:24 P.M. M
4. SOCIAL SECURITY NUMBER: 219-07-8872	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JULY 1, 1913	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): St. Mary's Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Leonardtown	9c. COUNTY OF DEATH: St. Mary's	

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: ST. MARY'S	10c. CITY, TOWN OR LOCATION: LEXINGTON PARK	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: RT. 1 BOX 182		10f. ZIP CODE: 20653	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER	16b. KIND OF BUSINESS/INDUSTRY: U.S.GOVERNMENT	
17. FATHER'S NAME (First, Middle, Last): ALEXANDER CLINTON		18. MOTHER'S NAME (First, Middle, Maiden Surname): LIZA CHESLEY	
19a. INFORMANT'S NAME (Type/Print): DELORES E. CLINTON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT.1 BOX 182, LEXINGTON PARK,MD. 20653	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. PETER CLAVER CEMETERY	20c. LOCATION — City or Town, State: ST.INIGOES,MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael K. Gardiner		22. NAME AND ADDRESS OF FACILITY: MATTINGLEY-GARDINER FUNERAL HOME,P.A. P.O. BOX 270,LEONARDTOWN,MD. 20650	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Recurrent Cerebrovascular Accident	3 hrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: A trial flutter, Obstruction arterial flow right leg

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D19917	29d. DATE SIGNED (Month, Day, Year): 8/17/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James C. Boyd, M.D. Leonardtown, Md. 20650		
31. DATE FILED (Month, Day, Year): AUG 22 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

4